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IN THE

# Supreme Court of the United States

DELTA FAMILY-CARE DISABILITY AND SURVIVORSHIP PLAN,

*Petitioner*,

—v.—

FRANK REGULA,

*Respondent*.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

## PETITION FOR WRIT OF CERTIORARI


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155 pgs

## QUESTIONS PRESENTED

1. Whether the Ninth Circuit erred in holding that a private disability plan subject to the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461 ("ERISA") must follow the Social Security Act's regulation giving controlling weight to the claimant's treating physician's opinion, a holding rejected by six other Circuits, and which conflicts with the deference accorded to benefit plan administrators under *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 112-13 (1989) and disrupts the uniform administration of benefit plans that is a primary goal of ERISA, *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001).

2. Whether the Ninth Circuit erred in holding that an ERISA plan which, as ERISA permits, is administered by employees of the employer and funded by an employer's irrevocable contributions to a trust established to pay benefits pursuant to the plan, suffers from a conflict of interest as a matter of law, a holding which is in conflict with the holdings of at least four other Circuits.

## LIST OF PARTIES

The only parties are those listed in the caption of this case.

## RULE 29.6 STATEMENT

Although Petitioner is not a corporation, it is a funded benefit plan sponsored by Delta Air Lines, Inc., which is a publicly-held corporation. *See* Sup. Ct. R. 29.6.

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ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

## PETITION FOR WRIT OF CERTIORARI

Delta Family-Care Disability and Survivorship Plan respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

## OPINIONS BELOW

The opinion of the court of appeals (App. *infra*, 1a-46a) is reported at 266 F.3d 1130. The opinion of the district court (App. *infra*, 47a-63a) is unreported.

## STATEMENT OF JURISDICTION

The judgment of the court of appeals was entered on September 24, 2001. An order denying a timely petition for rehearing *en banc* was entered on March 15, 2002. (App. *infra*, 67a-68a). This Petition for a Writ of Certiorari is filed within 90 days of that date. The Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

## STATUTORY PROVISIONS INVOLVED

Relevant provisions of the Employee Retirement Income Security Act of 1974, a regulation thereunder, and a regulation of the Social Security Act are reproduced in the Appendix, *infra*, 69a-99a.

## STATEMENT OF THE CASE

Frank Regula ("Regula") brought this action against the Delta Family-Care Disability and Survivorship Plan (the "Plan") in the United States District Court for the Central District of California seeking reinstatement of his long-term disability benefits under the Plan. The district court entered judgment in favor of the Plan. On the issues relevant to this petition, the district court held that the Social Security Act's treating-physician rule[1]

[1] The "treating-physician rule" is the commonly used term for a strong presumption that the opinion of the claimant's physician is to be followed in deciding whether a claimant is entitled to benefits. Because it actually only refers to the claimant's physician even when other physicians have examined claimant, it is more accurately called the "claimant's physician's rule." It is codified in Social Security Act regulations as a rule which gives the claimant's physician's opinion "controlling weight" if it is supported by accepted medical techniques and not inconsistent with other substantial evidence of record. 20 C.F.R. § 404.1527(d)(2). The Third Circuit has stated in Social Security Act cases that the claimant's physician's opinion is usually to be

had no application to ERISA-disability benefits cases and that the Plan's decision was not an abuse of discretion. Applying the treating-physician rule would improperly limit the discretion accorded to the Plan under controlling Supreme Court law. (Regula had not argued that the Plan operated under a conflict of interest).

The court of appeals, in a 2-to-1 decision, reversed. It held that the treating-physician rule should be applied to ERISA-disability benefit claims. It also held *sua sponte* that the traditional abuse of discretion standard of review did not apply because the Plan suffered from a *per se* conflict of interest. The court of appeals ordered that if the Plan could not rebut the presumption that the Plan's decision was the result of a conflict of interest, the *de novo* standard of review should apply.

## 1. Legal Background Regarding ERISA Claims.

ERISA-welfare benefit plan sponsors are generally permitted to decide what types of welfare benefits they will offer and on what terms those benefits will be provided. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983).[2] Disability benefits plans, like all welfare benefit plans, are exempt from ERISA's participation, vesting, funding and plan termination insurance obligations applicable to employee pension benefit plans. *See* 29 U.S.C. §§ 1051(1), 1081(a)(1) and 1321(a)(1). "ERISA

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given great weight. *See Morales v. Apfel*, 225 F.3d 310, 317 (3d Cir. 2000). The Ninth Circuit has phrased the rule somewhat differently in this case, stating that a Plan must have "specific, legitimate" reasons for rejecting a claimant's physician's opinion based on other evidence in the record. (App. *infra*, 16a-17a.) While the court of appeals avoided using the specific terms "controlling weight" or "great weight," the effect of the court of appeals' holding in this case is to afford such weight to the opinion of claimant's physician. *See infra*, p. 16.

[2] ERISA defines the term "employee welfare benefit plan" to include disability benefits plans. *See* 29 U.S.C. § 1002(1)(A).

itself 'does not regulate the substantive content of welfare-benefit plans.' " *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 515 (1997) (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985)).

In drafting ERISA, one of Congress's chief concerns was "not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). This concern was addressed by one of ERISA's goals, "which was to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.' " *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)). "Uniformity is impossible, however, if plans are subject to different legal obligations in different states." *Id.*

With respect to welfare benefit claims, by regulation ERISA imposes a mechanism for benefit claimants to administratively appeal adverse benefits decisions, which includes the right of the benefit claimant to submit information in support of a claim and to know the basis of the plan administrator's decision. *See* 29 C.F.R. § 2560.503-1. By statute, ERISA provides a mechanism for the enforcement of the terms of the Plan. *See, e.g.*, 29 U.S.C. § 1132(a)(1)(B). Further, when drafting ERISA, Congress specifically referred to the Social Security Act when it wanted to, *see* 29 U.S.C. §§ 1054(b)(1)(B)(iv), 1054(b)(1)(C), 1054(b)(1)(G); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 514-15 (1981) (same), but none of ERISA's provisions or regulations authorize the application of the Social Security Act's treating-physician rule.

In an action by a participant under 29 U.S.C. § 1132(a)(1)(B), the Plan's decision is subject to judicial review under either the arbitrary or capricious[3] or *de novo* standards, depending on the language of the Plan. *See Firestone Tire Co. v. Bruch*, 489 U.S. 101, 112-13 (1989). In *Firestone* this Court held that when a plan's terms vest discretion in the plan administrator to make benefits determinations, the determination will only be disturbed if it is arbitrary or capricious. *Id.* at 110-15. The level of deference given under that standard may be diminished by a demonstrated conflict of interest, but under *Firestone* a conflict of interest does not reduce the standard of review from arbitrary or capricious to *de novo*. *See id.* at 115.

Congress's approach in establishing a *public* welfare benefit plan was much different. Within the Social Security Act, Congress has established an elaborate, highly regulated public disability benefit authority. *See, e.g.*, 42 U.S.C. §§ 401-33; 20 C.F.R. §§ 404.1-.2127, 416.101-.2227. Although the review of Administrative Law Judge decisions under the Social Security Act is also by its terms somewhat deferential, that deference is within the much stricter confines of the Social Security Act's all encompassing regulatory scheme.

## 2. The Plan And Regula's Claim For Benefits.

This case involves an action by Regula for the reinstatement of his long-term disability benefits under the Plan. The Plan is a non-contributory, employee welfare benefit plan subject to ERISA. (App. *infra*, 101a-03a.) It provides, *inter alia*, long-term disability benefits to non-pilot employees of Delta Air Lines, Inc. (App. *infra*, 100a-01a.) It is funded by non-reversionary contribu-

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[3] The alternate term, "abuse of discretion," is used by some courts as being synonymous with "arbitrary or capricious."

tions to a benefits trust which pays benefits as approved by the Plan's administrator. (App. *infra*, 102a-03a.) The Plan's administrator is the Administrative Committee of Delta Air Lines, Inc., which is comprised of Delta employees. (App. *infra*, 103a-04a.)

To receive long-term disability benefits under the Plan, a claimant must be unable to "continuously and totally engage in any occupation whatsoever for compensation or profit, including part-time work." (App. *infra*, 100a.) The claimant must also remain under the care of a physician for his disabling condition. (App. *infra*, 100a.) The Plan requires the claimant to provide updated medical information at regular intervals. (App. *infra*, 4a, 49a & 100a-01a.) It is undisputed that the Plan's language gives the Plan's administrator sufficient discretion so that its decisions are reviewed under the abuse of discretion standard. (App. *infra*, 25a.)

In 1987, the Plan approved Regula's claim for long-term disability benefits. (App. *infra*, 4a.) Plaintiff claimed he was disabled due to an injured hand, back and neck and that he was psychiatrically disabled due to depression. (App. *infra*, 106a-09a.) The continued receipt of these benefits was expressly conditioned upon, among other items, Regula's provision of confirming medical evidence at regular intervals. (App. *infra*, 4a.)

In a report dated August 8, 1994, Regula's psychologist, Sandra Smith, Ph.D., stated that Regula might be able to engage in part-time work in six to twelve months with appropriate vocational rehabilitative services. (App. *infra*, 50a.) As of 1994, however, Regula's alleged orthopaedic injuries were no longer supported by an orthopaedist. (App. *infra*, 107a-08a.) Regula's Chiropractor, Dean H. Cummings, D.C., was the only individual who then stated Regula was disabled physically. (App. *infra*, 108a.)

At the Plan's request, Regula was then examined by Dr. Rajeshwari Kumar, an independent orthopaedic and vocational rehabilitative specialist. (App. *infra*, 6a & 50a.) Dr. Kumar examined Regula and detailed her findings in an 8-page report. (App. *infra*, 42a & 50a.) She concluded that Regula "is definitely [physically] capable of gainful employment performing some type of work." (App. *infra*, 42a.) After receiving Dr. Kumar's report, Dr. Smith, a psychologist, criticized Dr. Kumar's *orthopaedic* conclusions and separately reversed course, stating that Regula's psychological condition prevented him from working. (App. *infra*, 51a.)

After receiving Dr. Smith's criticism of Dr. Kumar's orthopaedic report and Dr. Smith's revised opinion regarding Regula's psychological ability to work, the Plan arranged for Regula to be examined by an independent psychiatrist, Dr. James O'Brien. (App. *infra*, 51a.) He concluded that Regula was "consciously exaggerating his psychological and orthopaedic difficulties." (App. *infra*, 6a.) Regula's resistance to any type of psychological treatment that would lead to symptomatic relief was also unjustified in Dr. O'Brien's opinion. (App. *infra*, 108a.) He concluded that "Mr. Regula can return to work immediately and that there is no type of work within his job description that he would not be able to do." (App. *infra*, 51a.)

The Administrative Committee was persuaded by Drs. Kumar and O'Brien's reports. (App. *infra*, 106a-09a.) It was also disturbed by Dr. Smith's criticism of the opinion of a professional outside of her area of practice and her failure to prescribe any medical therapy for Regula even though she posited that he was disabled. (App. *infra*, 107a-08a.) The Administrative Committee considered and rejected Regula's argument that the treating-physician rule applies to ERISA disability cases. (App.

*infra*, 108a-09a.) Even if the rule did apply, the Committee specifically explained that it credited Dr. Kumar's opinion more than Dr. Cummings' because Dr. Kumar was an examining orthopaedic specialist and Dr. Cummings was a chiropractor. Further, it credited Dr. O'Brien's opinion over that of Dr. Smith because of his specific reasons why he concluded that Regula was malingering. (App. *infra*, 109a.)

### 3. Proceedings In The District Court And The Court Of Appeals.

On October 17, 1996, Regula sued the Plan claiming that the termination of his long-term disability benefits was an abuse of discretion and violated ERISA. (App. *infra*, 51a.) The district court upheld the Plan's decision because the current medical evidence before the Administrative Committee demonstrated that Regula was not disabled as the Plan defines that term. (App. *infra*, 57a-59a & 65a.) (Regula did not contend that a conflict of interest affected the Plan's decision. App. *infra*, 47a-62a.) The district court rejected Regula's claim that the Plan must give greater weight to his chosen physician's opinion because that rule would materially diminish the discretion afforded to the Plan. (App. *infra*, 55a-57a.)[4]

A divided Panel of the Ninth Circuit reversed. (App. *infra*, la-46a.) First, the court of appeals held that the treating-physician rule, previously a product of only Social Security Act regulation and decisions, also applied to ERISA disability benefit claims. (App. *infra*, 15a-24a.) The court of appeals held that the rule would apply when an opinion of an independent physician contradicts the opinion of the claimant's physician and is not based on independent clinical findings, or rests on

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[4] The district court also rejected Regula's other arguments which are not relevant to this petition. (App. *infra*, 59a-62a.)

clinical findings also considered by the treating physician. (App. *infra*, 16a-17a.) In that event, the Plan's administrator can only reject the opinion of the treating physician only if it gives "specific, legitimate" reasons based on substantial evidence in the record. (App. *infra*, 17a.)

The court of appeals believed that the other Circuits were split on this issue. It characterized the Fourth Circuit as expressing in *dicta* doubts about the treating-physician rule's applicability in the ERISA disability-benefit claim context. (App. *infra*, 16a n.5.)[5] The court of appeals cited the Eighth Circuit as applying the rule, *though it noted that a more recent precedent, involving the very same benefit plan at issue in this case, apparently reached the opposite conclusion.* (App. *infra*, 16a n.5.)[6] The court of appeals noted that the Fourth, Fifth and Eleventh Circuit had rejected the rule in cases involving health benefits determinations as opposed to disability benefits terminations. (App. *infra*, 22a.)[7] The

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[5] *Id.* (citing *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607-08 (4th Cir. 1999)).

[6] *Id.* (citing *Donaho v. FMC Corp.*, 74 F.3d 894, 901 (8th Cir. 1996) and citing to *Delta Family-Care Disability & Survivorship Plan v. Marshall*, 258 F.3d 834, 842-43 (8th Cir. 2001) with the citation signal "*but see*").

[7] *Id.* (citing *Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 126 (4th Cir. 1994); *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992); *Jett v. Blue Cross and Blue Shield of Ala., Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989)). Since the Ninth Circuit's decision in this case, the Eleventh Circuit has held that the Ninth Circuit incorrectly read the Eleventh Circuit's rejection of the treating-physician rule too narrowly. In *Turner v. Delta Family-Care Disability and Survivorship Plan*, ___ F.3d ___, 2002 WL 1040194 *3-4 (App. *infra*, 116a) (11th Cir. Apr. 9, 2001), a case under this very Plan, the Eleventh Circuit rejected the application of the treating-physician rule to disability benefits claims.

Ninth Circuit distinguished these cases because it assumed that, unlike health insurance benefits payments, disability benefits are paid to the employee as opposed to the treating physician. (App. *infra*, 23a).

Second, the Ninth Circuit held *sua sponte* that the Plan's administrator, the Administrative Committee, operated under a *per se* conflict of interest. (App. *infra*, 26a.) It held that since the Plan was funded by Delta Air Lines, Inc. and decisions regarding the Plan were made by a committee composed of Delta employees, a *per se* conflict existed. (App. *infra*, 26a.) Then, citing the Administrative Committee's failure to apply the newly-minted treating-physician rule, it ruled that the conflict appeared to affect the Plan's actions. (App. *infra*, 30a.) The court of appeals ordered the district court to consider whether the Plan could rebut the presumption that the *per se* conflict affected the Administrative Committee's decision. (App. *infra*, 31a.) If the district court were to find that the conflict did affect the Administrative Committee's decision, then the court of appeals held that the district court must apply the *de novo* standard of review. (App. *infra*, 27a.)

Senior Circuit Judge Brunetti dissented. (App. *infra*, 31a-46a.) Because Judge Brunetti concluded that Regula waived any argument regarding a conflict of interest, he did not further address that issue. (App. *infra*, 32a.) Next, he concluded that the treating-physician rule should not apply to ERISA benefit claims. (App. *infra*, 37a-41a.) He noted that a Social Security regulation was an inapt analogy to ERISA. The Administrative Law Judge's disability determinations in the Social Security context are strictly confined by a complex regulatory scheme, while ERISA gives plans great discretion in determining whether to award benefits. (App. *infra*, 36a-37a.) For this reason Judge Brunetti stated that the court of appeals'

decision was inconsistent with the discretion accorded to the Plan under *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S., 101, 115 (1989). (App. *infra*, 37a.) He stated that his conclusion was consistent with Ninth Circuit precedent which rejected the importation of the Social Security Act's vocational evidence requirement to ERISA cases. (App. *infra*, 38a.)[8] According to Judge Brunetti *all* of the courts of appeals faced with the same issue disagreed with the Ninth Circuit in this case. (App. *infra*, 39a.)[9] Although Judge Brunetti noted that the Eighth Circuit's opinion in *Donaho* could be read to support the majority's application of the treating-physician rule, he noted that two cases, decided within the months prior to the court of appeals' decision in this case, minimized whatever precedential effect *Donaho* had. (App. *infra*, 40a.)[10]

Judge Brunetti also rejected the majority's distinction of cases applying the rule in the health-benefits claims context. "Because ERISA plans ordinarily requires a claimant to reprove their disability periodically," the physician opining disability in this case "almost guarantees another visit by that claimant" each time that he or she stated that the claimant was still disabled. (App. *infra*, 40a.) Finally, he noted that the Plan properly relied on the detailed reports of Drs. Kumar and O'Brien and held that the Plan also properly considered Dr. Smith's opinions to be less probative and potentially

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[8] *Id.* (citing *McKenzie v. General Tel. Co. of Ca.*, 41 F.3d 1310, 1317 (9th Cir. 1994)).

[9] *Id.* (citing *Dowden v. Blue Cross & Blue Shield of Texas, Inc.*, 126 F.3d 641, 644 (5th Cir. 1997); *Sheppard*, 32 F.3d at 126 (4th Cir.); *Jett*, 890 F.2d at 1139-40 (11th Cir.)).

[10] *Id.* (citing *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834, 842 (8th Cir. 2001); *Fletcher-Merrit v. NorAm Energy Corp.*, 250 F.3d 1174, 1180 n.3 (8th Cir. 2001)).

biased based on her statements about Dr. Kumar and her abrupt change in opinion. (App. *infra*, 41a-43a.)

The Plan filed a petition for rehearing *en banc* that raised both of the questions presented in this Petition. On March 15, 2002, the court of appeals denied the petition. (App. *infra*, 67a-68a.)[11]

## REASONS FOR GRANTING THE PETITION

The court of appeals' ruling improperly limits the discretion this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) accords to this and thousands of other welfare benefit plans with respect to both issues presented in the Petition. Just as importantly, the court of appeals' ruling disrupts a uniformity in federal benefits law that Congress sought in enacting ERISA by creating a conflict in the Circuits.

First, by applying the treating-physician rule to ERISA cases the court of appeals' decision mistakenly wrenches a single regulation from the Social Security Act's complex decision-making scheme and applies it to ERISA plans regulated by a simpler and less restrictive set of laws. The court of appeals' reasoning is even more problematic than its holding since it would be equally applicable to the importation of many other aspects of Social Security law to ERISA. The Ninth Circuit's reasoning is particularly harmful because it will lead to even greater commingling of the private and public benefits systems that Congress intended to keep separate.

The effect of applying this rule to future ERISA cases will be to give "controlling" or "great" weight to

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[11] The Order denying the petition specified that Judge Brunetti recommended granting rehearing *en banc* and that an active judge had requested a vote to rehear the case *en banc*, but did not state how many judges voted in favor of rehearing *en banc*. *Id.*

the claimant's physician in many cases. As a result, plans will face greater uncertainty in deciding claims since their discretion is cabined by this Social Security Act rule. In the long-term, this will require the application of different rules to beneficiaries under the same plan, a result which will necessarily increase the costs of administering such a plan. Costs will also be increased either by either awarding benefits in borderline cases where they should not be awarded or by increasing the litigation of these cases decided by the plan. The likely, but unfortunate consequence of this increase in costs will inevitably be the reduction of at least the amount of benefits, if not the type of benefits, available to employees. *See Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001) (consequences of additional administrative burdens on ERISA plans will ultimately harm beneficiaries).

The aggregate amount of plan participants and the dollar amount of benefits at issue is staggering. This is a benefit which over 50% of the employees of medium and large-size companies (*i.e.*, 100 or more employees) in America elect. *See* Bureau of Labor Statistics, National Compensation Survey for 1999, *www.bls.gov/news.release/ebs2.t02.htm*. Further, in the most recent year reported, this Plan alone had over 71,000 participants and paid over $32 million ($32,000,000.00) in benefits directly to participants. *See www.freeerisa.com/5500/InstantView.asp?MainID=298336* (refer to lines 7(d) and 32(e)(1)). Given that the benefits provided by the Plan are not unique to Delta Air Lines, Inc., the plan sponsor in this case, similar amounts can be expected to be paid under similar circumstances by other large corporations.

Second, the court of appeals' decision is also contrary to the decisions of the Eighth and Eleventh Circuits

*regarding this very Plan* and also contrary to the decisions of the Fourth, Fifth, Sixth and Seventh Circuits on this issue generally. The Ninth Circuit's decision in this case places this Plan, and any other plan which operates is in the Ninth and any of these other six federal Circuits, under directly conflicting rules regarding the administration of their plans. This result is directly contrary to Congress's goal of uniformity when it enacted ERISA. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) (it is difficult to achieve ERISA's goal of a uniform administrative scheme when a plan is subject to differing regulatory requirements in different states.)

The court of appeals also held that a *per se* conflict of interest exists under *Firestone* whenever employees of the plan sponsor make decisions regarding the distribution of funds from the plan, even though those funds can never revert to the plan sponsor. This ruling is in direct conflict with at least the Eleventh Circuit regarding this very Plan and the Third, Seventh and Tenth Circuits generally. Similar to the conflict in the Circuits regarding the treating-physician rule, this conflict will subject claimants under the same Plan to different outcomes based on the same facts in cases decided by the district courts in these four Circuits. This too is directly contrary to Congress's express purpose for enacting ERISA—to apply one body of law and one set of rules to these claims. *See id.*

These conflicts will not be resolved by the courts of appeals. On both issues, the Eleventh Circuit has recently and expressly reaffirmed its position and rejected the Ninth Circuit's position in this case. The Ninth Circuit has refused *en banc* review in this case. These conflicts are not likely to abate and will continue to recur in the future. *See infra*, pp. 21-22 & 25. The only practical resolution of these issues is through review by this Court.

## I. Certiorari Should Be Granted On The Question Presented Regarding The Application Of The Treating-Physician Rule To ERISA Disability Benefits Cases Because It Is A Significant Error Which Has Divided The Circuits And Requires Correction By This Court.

The Ninth Circuit in this case held that the treating-physician rule applies to ERISA-disability benefits claims. In doing so, the Ninth Circuit borrowed a Social Security Act rule which Congress had chosen not to adopt for ERISA. To compound this error, the Ninth Circuit's decision also creates a conflict with six other Circuits which places thousands of benefits plans in the untenable position of applying different rules to different participants despite the claimants' rights arising from the identical terms of a single plan. The conflict is even more egregious as it affects a statute that Congress created to provide uniform standards for plan administration, *see Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001), as evidenced by its provision preempting laws that relate to ERISA plans which this court has called "deliberately expansive." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987).

The result of this rule will be the transfer of much of the fiduciary/plan administrator's discretion to an individual who has no duty to fairly or uniformly administer the plan—the claimant's physician. This forced delegation runs directly counter to ERISA's imposition of a fiduciary duty on a plan administrator to administer the plan "in accordance with the documents and instruments governing the plan." *See* 29 U.S.C. § 1104(a)(1)(D).

The Ninth Circuit in this case tried to downplay the effect of giving "controlling" or "great" weight to the claimant's physician by (1) omitting those terms from its characterization of the rule, *see supra*, n.1, and (2) stat-

ing that a plan could meet the rule by giving "specific, legitimate" reasons for disagreeing with the treating physician. But its implementation of that rule flatly belies its use of neutral terms. For example, in this case the Administrative Committee specifically articulated specific and legitimate reasons for not following the opinions of Regula's two physicians. It chose not to follow the opinion of a chiropractor over the detailed opinion of a board-certified orthopaedic and rehabilitative specialist because it valued the professional expertise of an orthopaedic specialist more than that of a chiropractor. (App. *infra*, 109a.)[12] It chose not to follow the opinion of Regula's psychologist, Dr. Smith, because she had evidenced bias on Regula's behalf by criticizing *orthopaedic* conclusions of Dr. Kumar even though they were outside Dr. Smith's area of practice and because she continued to opine that Regula was disabled, but did not prescribe any of the available medications that could assist Regula. (App. *infra*, 109a.) If these reasons did not meet the Ninth Circuit's criteria for specificity and legitimacy, then the result is that the court of appeals' rule will nearly always require a plan to give controlling weight to the claimant's physician. The purported "specific, legitimate" reasons exception to the rule is undefined and illusory.

The court of appeals' adoption of this rule ignores (1) the effect of its conflict with this Court's decision in *Firestone*; and (2) the fact that its comparisons between ERISA and the Social Security Act are inapt. First, even the Ninth Circuit recognized that the application of the treating-physician rule would reduce the discretion afforded to plans under this Court's decision in *Firestone*. (App. *infra*, 17a.) It now requires (as shown by

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[12] Regula failed to explain why he chose not to submit current reports from an orthopaedist of his own choosing.

the rule's application to this case) that plans give controlling weight to a claimant's physician even when the plan administrator specifically explains that it is not persuaded by those physicians based on substantial evidence in the record, inferior credentials or bias. Application of this rule to ERISA benefits claims improperly diminishes the authority vested in this Plan pursuant to *Firestone*. (App. *infra*, 37a-40a.) (Brunetti, J. dissenting); *Dowden v. Blue Cross & Blue Shield of Tex.*, 126 F.3d 641, 644 (5th Cir. 1997).

Indeed, *Firestone's* only mention of circumstances that would diminish the discretion afforded to a plan administrator under a plan's terms involved conflicts of interest. *Firestone*, 489 U.S. at 115. It contemplates no other limits on the Plan's discretion that are not contractually based, or in the terms of the Plan, ERISA or its regulations. *Id.* As *Firestone* observed, ERISA already mandates that a plan be administered by a fiduciary. 489 U.S. at 109. However, the Ninth Circuit turns the discretionary and fiduciary aspects of *Firestone* on their respective heads by requiring a plan's fiduciary to give great weight to a physician with a fiduciary duty *to the claimant* and *no duty to the plan or its other participants*. *See Manion v. N.P.W. Med. Center of N.E. Pa.*, 676 F. Supp. 585, 588 (M.D. Pa. 1987) (medical professional's fiduciary duty is to his client).

Further, the manner in which benefits claims are to be handled by claims administrators is already subject to regulation under ERISA. 29 C.F.R. § 2560.503-1. That claims handling regulation creates no requirement that a plan administrator apply the treating-physician rule. This is not a case where it can be argued that there was room for the Ninth Circuit to create federal common law in an area neither reserved for the plan's terms nor covered by the statute or regulation. Indeed, when Congress

desired to integrate the terms of the Social Security Act and ERISA, it did so explicitly. *See* 29 U.S.C. §§ 1054(b)(1)(B)(iv), 1054(b)(1)(C), 1054(b)(1)(G); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 514-15 (1981) (same).

The court of appeals' decision in this case also erroneously draws a line between health benefits cases and disability benefits cases on the ground that physicians opining in disability cases have no financial bias in favor of claimants. As Judge Brunetti correctly points out, the treating physician is under an incentive in both sets of cases to opine favorably to the claimant. (App. *infra*, 40a); *see Pegram v. Herdrich*, 530 U.S. 211, 218 (2000) (in a fee-for-service system, the incentive is on the physician to provide more care). In the health benefits context, the requested treatment will be paid for (which produces income to the treating physician) and in the disability context, the claimant will return at the intervals required by the Plan for another examination (which also produces income to the treating physician). (App. *infra*, 40a.) Thus, the court of appeals' decision upends the playing field for plan administrators by effectively prohibiting the plan administrator from considering bias on behalf of the claimant's physician (as the Plan did in this case based on Dr. Smith's own comments), yet assumes bias on behalf of a physician hired by the Plan. (App. *infra*, 23a.)

The court of appeals' decision is also problematic because it rests on reasoning that can be readily applied to many other provisions of the Social Security Act. The court of appeals said that the treating-physician rule should apply because it would 1) force the administrator to create a better record for review and 2) increase consistency between the Social Security Act and ERISA plan disability decisions. (App. *infra*, 15a-16a.) Given

the pervasively regulated nature of Social Security claims, almost all of Social Security law fits this bill. But this consistency is not what Congress intended or else it would have required ERISA disability benefit plans to adopt standards for disability similar to the Social Security Act standard and would have otherwise extensively regulated claims process as it did with the Social Security Act. It did neither of these as ERISA was in large part intended to encourage employers to provide these additional benefits by avoiding regulatory complexity. *See Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (Congress balanced "its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place" with enhanced protection for beneficiaries).

Indeed, the end result of the Ninth Circuit's "goal" of consistency would be to require ERISA plans to follow Social Security disability decisions since ERISA plan administrators are to follow Social Security Act rules. *This "end result", however, has been rejected by not only the Ninth Circuit itself, see Madden v. ITT LTD Plan for Salaried Employees*, 914 F.2d 1279, 1286 n.6 (1990), but by many other circuits as well with respect to governmental disability programs in general. *See Delta Family-Care Disability & Survivorship Plan v. Marshall*, 258 F.3d 834, 842 n.11 (8th Cir. 2001) (under the same Plan at issue in this case, because of greater discretion granted to ERISA plan administrators, governmental disability decisions need not be followed by the Plan); *Paramore v. Delta Air Lines, Inc.*, 129 F.3d 1446, 1452 n.5 (11th Cir. 1997) (concerning Social Security); *see also Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 442-43 (2d Cir. 1995) (differing standards of disability preclude similar results); *Hale v. Trustees of United Mine Workers' Health & Retirement Funds*,

23 F.3d 899, 902 (4th Cir. 1994) (same); *Brown v. Retirement Comm. of Briggs & Stratton Retirement Plan*, 797 F.2d 521, 529 (9th Cir. 1986) (same). Given that the Ninth Circuit's "goal" of consistency is (1) not what Congress desired, and (2) not attainable, the adoption of the treating-physician rule to reach the goal is contrary to law. The reasoning of the court of appeals is in error which, if left unreviewed, will lead to the further misimportation of Social Security Act law to ERISA.

As if this were not enough, the Ninth Circuit's decision stands alone among those courts of appeals that have reached this issue. All six others have rejected it. *See Elliott*, 190 F.3d at 604 (4th Cir.); *Sheppard & Enoch Pratt Hosp.*, 32 F.3d at 126 (4th Cir.); *Dowden*, 126 F.3d at 644 (5th Cir.); *Wilczynski v. Kemper Nat'l Ins. Co.*, 178 F.3d 933, 938 (7th Cir. 1999); *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d at 842 (8th Cir.);[13] *Turner v. Delta Family-Care Disability and Survivorship Plan*, ___ F.3d ___, 2002 WL 1040194 *3-4 (App. *infra*, 116a) (11th Cir. Apr. 9,

[13] The Eighth Circuit has rejected the application of the treating-physician rule in ERISA cases and the court of appeals was incorrect to the extent it read Eighth Circuit law to the contrary. As Judge Brunetti noted in dissent, the Eighth Circuit (in a case involving this very Plan) did not apply the treating-physician rule in *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d at 842. The Eighth Circuit case that the Ninth Circuit cited to the contrary, *Donaho v. FMC Corp.*, 74 F.3d 894, 901 (8th Cir. 1996), did not involve a conflict of opinion between doctors who had actually examined the claimant. In fact, every doctor who examined the claimant in that case stated that claimant was disabled under FMC Corp.'s plan's definition of disability. *Id.* at 901. Given that the *non-examining* physician had previously thought that the claimant was disabled based on the opinions from the same medical professionals and then changed his mind, there was a hint in the factual circumstances of that case that the non-examining physician's opinion was not just mistaken, but disingenuous. *Id.* (To the contrary, this case involves only physicians who actually examined Regula).

2002) (per curiam); *Jett*, 890 F.2d at 1140 (11th Cir.). The Sixth Circuit also rejected the rule in its recent unpublished opinion in *Jackson v. Metropolitan Life*, 2001 WL 1450811 *2 (6th Cir. Oct. 29, 2001) (following the Eighth Circuit's opinion in *Delta Family-Care Disability & Survivorship Plan v. Marshall* and rejecting the rule). Since the court of appeals' decision in this case, the Eleventh Circuit has affirmed its rejection of the treating-physician rule and rejected *Regula's* holding by name in *Turner*, ___ F.3d at ___, 2002 WL 1040194 *3-4 (App. *infra*, 116a). In noting that the court of appeals' decision in this case is not the law of the Eleventh Circuit, *Turner, a case involving the very same benefit plan at issue in this case*, has rejected *Regula's* limitation of the Eleventh Circuit's previous decision in *Jett* to medical benefit cases only. *Id.*[14]

This is not a conflict which will be resolved by the Circuits. The Ninth Circuit has already refused to accept the case for *en banc* consideration even though it knew that it was placing this Plan in the position of interpreting its terms inconsistently with respect to its beneficiaries in the Eighth and Eleventh Circuits. This virtually guarantees that the Circuit split on this issue will remain (and likely deepen) without resolution by this Court.[15]

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[14] The claimant in *Turner* offered not to pursue a petition for a writ of certiorari or petition for rehearing in exchange for the Plan's promise not to recover its costs and fees. The Plan essentially accepted Plaintiff's offer so the decision in *Turner* is final.

[15] Many other cases which had not specifically considered the treating-physician rule, reached conclusions which foreclosed any possibility of the treating-physician rule's application. Before the court of appeals' decision in this case, it was common across the Circuits to hold that a Plan's decision was not arbitrary or capricious (or an abuse of discretion) as a matter of law when the opinions of a treating physician and of another physician who examined the claimant

In fact, the conflict already appears to be deepening. While there have been no new decisions holding that the treating-physician rule should apply to ERISA disability benefit claims cases when a plan administrator has discretion to decide disability benefit claims, two recent decisions show differing levels of potential support for the rule. The Second Circuit, in *Connors v. Connecticut General Life Insurance Corp.*, 272 F.3d 127, 135 n.4 (2001), actually rejected the treating-physician rule in a case in which *de novo* review applied, but indicated *in dicta* that it might apply the rule when the plan's terms provided the plan administrator with discretion to decide benefit claims. If the Second Circuit were to follow its *dicta* in *Connors*, it would take the odd position that plan administrators who are given discretion to decide benefits claims actually have less discretion to reject the treating physician's opinion. Further, in *Skretvedt v. E.I. Dupont de Nemours*, 268 F.3d 167, 184 (3rd Cir. 2001), the Third Circuit mentioned the treating-physician rule and cited *Regula* but there was no conflict of physician opinions in that case. While *Skredvedt* only mentions the rule in *dicta* and appears contrary to the Third Circuit's prior decision in *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 43 (3d Cir. 1993), which permitted the plan to rely on either of the conflicting physicians' opinions, it is further evidence that the split on this issue is deepening.

Further review of this case by this Court is warranted because this matter is likely to recur frequently and is not capable of resolution by the courts of appeals.

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were in conflict. *See, e.g., Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994); *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 47 (3d Cir. 1993). Even putting these cases to the side, the Ninth Circuit is the only court of appeals to have adopted the rule.

## II. Certiorari Should Be Granted On The Conflict Of Interest Issue Because It Requires Different District Courts To Reach Conflicting Decisions Under The Same Plan.

The Ninth Circuit's decision in this case also conflicts with the conclusions of other circuits as it mistakenly holds that a *per se* conflict of interest exists, even if the plan irrevocably sets aside funds for the payment of benefits for its employees, when the plan sponsor's employees decide claims under the Plan. Further, while in *Firestone* this Court held that a conflict of interest would affect the degree of discretion afforded to the plan administrator, *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) the Ninth Circuit has gone further in this case and held that a conflict of interest can require the application of *de novo* review. (App. *infra*, 27a). The Ninth Circuit's conclusion is also in direct conflict with a decision of the Eleventh Circuit regarding this very Plan, and the Third, Seventh and Tenth Circuits on this issue generally. Most importantly, the Eleventh Circuit considered this rule again in April of this year, in light of the Ninth Circuit's decision in this case, and affirmed that no conflict of interest existed under the same facts and involving the very same plan as this case. *See Turner v. Delta Family-Care Disability & Survivorship Plan*, ___ F.3d at ___, 2002 WL 1040194 *3 (App. *infra*, 115a-16a).

The court of appeals' holding rests on the mistaken, *per se*, assumption that a plan sponsor's employees acting in a fiduciary capacity would be more likely to deny benefits to a claimant—presumably to reduce the amount of monies that the sponsoring company needs to pay for benefit claims in the future. (App. *infra*, 26a.) But the basis for that ruling rests on nothing more than that: an

unproven, counter-intuitive assumption which has been rejected by this Court and at least four other Circuits.

First, the Ninth Circuit's *per se* approach ignores the fact that these employees are acting as plan fiduciaries, and are held to ERISA's extremely high standards requiring them to act only in the best interest of the plan participants and beneficiaries. *See* 29 U.S.C. § 1104(a)(1). It also ignores the fact that ERISA prohibits fiduciaries from acting in the best interest of the employer. *See* 29 U.S.C. § 1106(b). In fact, ERISA subjects any fiduciary who ignores these duties to *personal* liability. *See* 29 U.S.C. § 1109(a). While ERISA's fiduciary provisions require plan fiduciaries to avoid conflicts of interest, *see Mertens v. Hewitt Assoc's.*, 508 U.S. 248, 252 (1993), it permits the plan sponsor's employees to be the administrator and trustee of the plan. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 105 (1989). Thus, ERISA starts from a presumption that such an arrangement does not pose a conflict of interest.

Second, fiduciary duties aside, since a welfare benefit plan is a substitute for compensation, benefit plans are established to attract employees, *see Lockheed Corp. v. Spink*, 517 U.S. 882, 893 (1996), and pay benefits when they are due according to the Plan's terms so that placing the funding and decision-making functions in the same entity does not create a conflict of interest. "[B]enefits are a valued component of total compensation, so that the employer who is tightfisted in computing benefits, or who gets a reputation for unfairness in passing on claims, may find himself having to pay higher wages." *Gallo v. Amoco Corp.*, 102 F.3d 918, 921 (7th Cir. 1996). Courts have embraced this truism by holding that there is no conflict of interest when a plan is self-funded through contributions to a trust that are irrevocable *even if* the employer's employees decide the

claims for benefits. *See Abnathya v. Hoffmann-La Roche Inc.*, 2 F.3d 40, 43 (3d Cir. 1993); *Gallo*, 102 F.3d at 921; *Woolsey v. Marion Lab's, Inc.*, 934 F.2d 1452, 1459 (10th Cir. 1991); *Buckley v. Metropolitan Life Ins., Inc.*, 115 F.3d 936, 938 (11th Cir. 1997) (per curiam). Contrary to these decisions, the Ninth Circuit held in this case that this arrangement creates a *per se* conflict of interest. (App. *infra*, 26a.)[16] Especially when Delta had no duty to fund the Plan, *see Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995), but did so with *irrevocable* contributions, and any employer could lawfully revise a plan to reduce the amount of benefits paid should it be concerned with the amount of claims, *see Hughes Aircraft Co. v. Jacobsen*, 525 U.S. 432, 444 (1999), the Ninth Circuit's *per se* rule is illogical and contrary to law.

Like the conflict in the Circuits regarding the treating-physician rule, this conflict will not abate. In *Turner*, the Eleventh Circuit reaffirmed its rejection of the court of appeals' decision in this case and the Ninth Circuit has rejected *en banc* review. (App. *infra*, 67a-68a); *Turner*, ___ F.3d at ___, 2002 WL 1040194 *3 (App. *infra*, 115a-16a). Also, similar to the treating-physician issue, the conflict in the Circuits regarding the *per se* conflict of interest rule subjects participants under the identical terms of the same Plan to divergent results. Here, the divergent results occur when courts in different Circuits apply different standards of review to cases involving the same facts and reach different results.

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[16] Ironically, according to the court of appeals, the primary *proof* that this alleged *per se* conflict affected the Plan's decision in this case, was the plan administrator's failure to apply the treating-physician rule—a rule which had been rejected by every other court of appeals which considered this issue at the time the Plan's decision in this case was made.

Finally, as noted above, the number of participants and the dollar value of benefits at issue are tremendous when considering all plans subject to these conflicts. These differing outcomes insert an element of inherent geographic chance and unfairness into what is otherwise intended to be a uniform system of benefit payments administered by fair-minded fiduciaries. For these reasons, intervention by this Court is needed to resolve this conflict.

## CONCLUSION

The Petition for Writ of Certiorari should be granted.

Respectfully submitted,

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June 12, 2002

# APPENDIX

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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No. 98-55853
D.C. No. CV-96-07304-RSWL

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FRANK REGULA,

*Plaintiff-Appellant,*

—v.—

DELTA FAMILY-CARE DISABILITY
SURVIVORSHIP PLAN,

*Defendant-Appellee.*

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Appeal from the United States District Court
for the Central District of California
Ronald S.W. Lew, District Judge, Presiding

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Argued and Submitted
October 6, 1999—Pasadena, California

Filed September 24, 2001

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Before: Betty B. Fletcher, Dorothy W. Nelson,
and Melvin Brunetti, Circuit Judges.

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Opinion by Judge B. Fletcher;
Dissent by Judge Brunetti

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Hunter B. Hughes, Atlanta, Georgia, for the defendant-appellee.

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## OPINION

B. FLETCHER, Circuit Judge:

Frank Regula appeals the district court's denial of his motion for summary judgment on his claim that the Delta Family-Care Disability Survivorship Plan ("Delta Plan" or "Plan") abused its discretion in terminating his disability benefits. Specifically, Regula contends that the Delta Plan should have accorded deference to the opinions of his treating physicians and considered vocational evidence in making its benefits determination. Regula also sought summary judgment on the ground that the Delta Plan failed to provide him with a full and fair review of his disability claim. The district court denied Regula's summary judgment motion in its entirety and entered judgment in the Plan's favor pursuant to a stipulation signed by the parties. We vacate the judgment of the district court and remand for a determination as to whether the Delta Plan may have been acting under a conflict of interest, and thus whether the court should have applied a less deferential standard of

review to the Plan's decision to discontinue Regula's benefits.

I.

The Delta Plan is a non-contributory employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The Plan provides short- and long-term disability benefits to non-pilot Delta employees.

Under the Plan, a participating employee is eligible for short-term disability benefits "when he is disabled as a result of a demonstrable injury or disease (including mental or nervous disorders) . . . which prevents the Employee from engaging in his customary occupation." An eligible employee can qualify for short-term disability benefits for up to eighteen months with the approval of the Plan's Administrative Committee. Once the short-term disability benefits expire, a participating employee is eligible for long-term disability benefits if "he is disabled at that time as a result of demonstrable injury or disease (including mental or nervous disorders) which will continuously and totally prevent him from engaging in any occupation whatsoever for compensation or profit, including part-time work." An employee is eligible for longterm benefits "so long as he remains disabled." In addition, an employee must be "under the care of a physician or surgeon for the injury or disease" to remain eligible for such benefits. The Administrative Committee determines whether a participant is "disabled" and is therefore eligible for benefits.

The Administrative Committee also serves as the "named fiduciary" of the Plan and has "authority to control and manage the operation and administration of the plan." As part of its function, the Administrative Com-

mittee is given "the exclusive power to interpret [the Plan]" and "its interpretation and decisions [are] final and conclusive." Furthermore, the Committee is charged with "decid[ing] all questions concerning the Plan."

The Plan has a two-tiered review procedure governing appeals from a claims denial. The Plan's Administrative Subcommittee provides the first level of review. If the claimant is not satisfied with the outcome of the Subcommittee's decision, the claimant may then appeal to the full Administrative Committee. During either level of the review process, the claimant or his representative is entitled to review "pertinent documents relating to the denial and may submit written comments."

Frank Regula began his employment with Western Airlines ("Western") in 1971 and functioned normally in his job until sustaining "a severe injury to the neck, right shoulder and arm during the course of his employment" as a clerk in October 1985. Nearly two years later, Regula filed a claim for short-term disability benefits, claiming that he had sustained a "cervical disc injury." The Delta Plan granted Regula's request and awarded him short-term disability benefits through October 30, 1987.

The Plan then awarded Regula long-term disability benefits beginning in November 1987 and approved the continuation of these benefits on thirteen separate occasions. The Plan reviewed Regula's disability award every three months, and notified him each time that he would be required to submit an updated physician's report to prove his continued eligibility for benefits. Throughout this period, Regula continued to demonstrate his eligibility by submitting updated reports from his treating physicians. On July 25, 1995, however, the Plan terminated Regula's long-term disability benefits because it determined that he was capable of working,

rendering him ineligible for benefits under the definition of "Long Term Disability" in section 4.03 of the Plan.

Regula submitted two contemporaneous reports by his treating physicians in support of his claim for continued disability benefits.[1] In the first report, Dr. Sandra Smith, a psychologist, opined that it was "very probable" that Regula was still disabled in the summer of 1994. In response to an inquiry from the Plan about the possibility of vocational rehabilitation, Dr. Smith further clarified her diagnosis by declaring that Regula's "combined physical and emotional symptom complex" prevented him from enrolling in a vocational rehabilitation program. As a psychologist, Dr. Smith stated that her diagnosis was limited to Regula's psychological condition and that she would "defer . . . to an appropriate medical specialist concerning Regula's physical symptoms."

Regula's second report, prepared by Dr. Dean H. Cummings, provided a diagnosis of Regula's continuing physical symptoms. In that report, Dr. Cummings concluded that Regula was still "permanently disabled" in December 1994 due to the "undesirable effects of multiple surgeries." Specifically, Dr. Cummings cited Regula's "[i]nability to sustain repeated or prolonged standing, sitting, pulling, pushing, bending, stooping, lifting to waist level, lifting over [his] head, walking, exerting or sitting for 10 minutes or more" as disabling factors.

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[1] As the district court pointed out, the physicians who examined Regula during this period included Drs. Michael Smith, H. Dale Richardson, Peter Schou, Alfred Bloch, Burton Wixen, Sandra Smith, and Dean H. Cummings. By Regula's own admission, with the exceptions of Dr. Sandra Smith and Dr. Cummings, none of these physicians examined Regula within the four years prior to the Plan's 1995 termination of his long-term disability benefits. A lengthy discussion of these superannuated reports is therefore unnecessary.

In response to Regula's two reports, the Delta Plan arranged for Regula to be examined by Dr. Rajeswari Kumar, a specialist in physical and rehabilitative medicine. Dr. Kumar diagnosed Regula with chronic pain syndrome, post-traumatic pain in the cervical and lumbar regions, status post-anterior diskectomy at C5-6 and C6-7, and status post-decompression of superficial radial nerve, right upper extremity. Nevertheless, Dr. Kumar concluded that Regula was "definitely capable of gainful employment performing some type of work." Dr. Kumar also noted that Regula could perform several specific activities including, most notably, standing and walking for four to six hours per day. These considerations led Dr. Kumar to conclude that Regula was not disabled.

In addition, the Plan arranged for a psychiatrist, Dr. James O'Brien, to assess Regula's psychological condition. After examining him, Dr. O'Brien concluded that Regula was "consciously exaggerating his psychological and orthopedic difficulties." In response to the report prepared by Regula's psychologist, Dr. Smith, Dr. O'Brien specifically attacked Dr. Smith's diagnosis as biased because she expressed opinions about Regula's physical condition that were outside of her field of expertise. Consistent with Dr. Kumar's report, Dr. O'Brien also concluded that "Mr. Regula can return to work immediately and that there is no type of work within his job description that he would not be able to do." Thus, both of the Delta Plan's examiners concluded that Regula was not disabled.

Based on these reports, the Plan terminated Regula's long-term disability benefits in a letter dated July 25, 1995. The letter also notified Regula that the Plan would reconsider its decision, but that he must submit "objective evidence that [he is] continuously and totally dis-

abled from engaging in any occupation or work for compensation or profit" in order to perfect his claim.

Regula then appealed the denial of his long-term disability benefits to the Administrative Subcommittee. The Plan sent Regula's attorney, Lawrence Rohlfing, a letter informing him about a claimant's right "to review pertinent documents related to [his] appeal and submit other comments, issues or evidence in further support of the appeal to the Subcommittee." In response, Rohlfing submitted additional superannuated reports from Drs. Shapero and Smith, along with a fourpage letter setting forth Regula's legal and factual case for continued eligibility. Nevertheless, the Administrative Subcommittee rejected Regula's appeal. The Plan communicated its rejection through a letter citing specific parts of the Plan's examining physicians' reports that supported the Subcommittee's decision.

After the rejection of his appeal on the first level of review, Regula appealed to the full Administrative Committee. The Secretary of the Administrative Committee wrote a letter to Rohlfing delineating the types of evidence that could be submitted to perfect Regula's claim. This letter was received only six days prior to the scheduled date of the hearing. Recognizing that the letter did not grant Regula a sufficient amount of time to collect and submit additional evidence, the Plan offered him an extension of time. Regula refused the Plan's offer. Following a hearing, the Administrative Committee notified Regula that it was rejecting his appeal and informed him that he was no longer eligible for long-term disability benefits under the terms of the plan.

Regula subsequently filed an action against the Delta Plan in federal district court on October 17, 1996, alleging that the Plan's denial of his long-term disability benefits violated ERISA. On February 17, 1998, the district

court denied Regula's motion for summary judgment. The district court held that substantial evidence supported the Plan's decision and that the Plan did not abuse its discretion as a matter of law. In finding for the Plan, the district court rejected several arguments that it viewed as a circumvention of the broad discretion afforded to Plan Administrators. First, the district court refused to apply the "treating physician rule" in an ERISA case. Second, the district court rejected Regula's contention that the Plan's failure to consider vocational evidence was an abuse of discretion. Finally, the district court found that the Plan had conducted a full and fair review of Regula's claim.

Following the denial of Regula's summary judgment motion, the parties agreed to the following stipulation:

> TO THE HONORABLE RONALD S. W. LEW, JUDGE OF THE DISTRICT COURT:
>
> Whereas plaintiff Frank Regula filed a motion for summary judgment in the above-captioned matter on August 11, 1997, which defendant Delta Family-Care Disability and Survivorship Plan opposed;
>
> Whereas the court has issued an order denying plaintiff's motion for summary judgment;
>
> Whereas the issues at trial are identical to those issues set forth in plaintiff's motion for summary judgment and defendant's opposition thereto;
>
> Whereas of the facts before the court at trial are limited to the record before the plan administrator of defendant, consisting of the record before the court on the motion for summary judgment; and
>
> Whereas the parties wish to preserve scarce resources;

THE PARTIES HEREBY STIPULATE AND AGREE AS FOLLOWS:

If the "treating physician rule" does not apply to ERISA cases, and if the Administrative Committee's decision that plaintiff was no longer entitled to long term disability benefits was not, as a matter of law, an abuse of discretion, and if plaintiff was not denied an opportunity for full and fair review, then plaintiff cannot prevail at trial and defendant is entitled to judgment.

Plaintiff Frank Regula has preserved his rights to appeal on his contentions raised in his motion for summary judgment. The court has necessarily rejected as a matter of law each of the points raised.

Based upon the decision of the District Court, defendant is entitled to judgment.

IT IS SO STIPULATED.

The district court approved the stipulation by entering judgment. Regula then filed this appeal pursuant to 28 U.S.C. § 1291, which grants this court appellate jurisdiction over a final decision of the district court.

II.

A district court's denial of summary judgment is ordinarily not appealable. *California v. Campbell*, 138 F.3d 784, 786 (9th Cir. 1998); *see also Behrens v. Pelletier*, 516 U.S. 299, 306-07 (1996) (holding that a denial of immunity is within a small class of cases that are immediately appealable from a denial of summary judgment). The so-called final judgment rule allows parties to appeal only final decisions of the district courts. *See* 28 U.S.C. § 1291. A final judgment is " 'a decision by the

District Court that ends the litigation on the merits and leaves nothing for the court to do but execute the judgment.' " *Dannenberg v. Software Toolworks Inc.*, 16 F.3d 1073, 1074 (9th Cir. 1994) (quoting *Coopers & Lybrand v. Livesay*, 437 U.S. 463, 467 (1978)). The purpose of the final judgment rule is to ensure that all claims are raised in a single appeal to avoid piecemeal adjudication of a single controversy. *See Cobbledick v. United States*, 309 U.S. 323, 325 (1940).

As an appellate court, we are required to raise the finality of the district court's order sua sponte on appeal. *See In re Exennium, Inc.*, 715 F.2d 1401, 1402 (9th Cir. 1983). As we noted in *Dannenberg*, this court takes a "pragmatic approach to finality," and there are situations when a stipulated judgment may fulfill the purposes underlying the final judgment rule. 16 F.3d at 1075. These limited cases arise only when all the claims that may be the subject of an appeal have become sufficiently finalized. *See id.* Thus, although the parties in this case stipulated to the judgment, we have jurisdiction only if the stipulated judgment sufficiently finalized the district court's order denying Regula's summary judgment motion. We conclude that the stipulated judgment so finalized Regula's appeal.

The district court's denial of Regula's motion for summary judgment conclusively decided the legal and factual issues in the case. As stated in the stipulation, the parties agreed that Regula could not prevail at trial after the denial of his summary judgment motion. Accordingly, the parties stipulated to the judgment to facilitate the immediate appeal of an ordinarily nonappealable order in an effort to "preserve scarce resources." The stipulation placed all the issues before this court for de novo review, preserving resources because there were no undecided issues that could subject this court to the

threat of piecemeal adjudication through multiple appeals. The district court then properly finalized the stipulation by entering judgment in favor of the Plan.

In a nearly identical case, we held that parties may stipulate to a final judgment if all the issues in the case are placed in this court on appeal. *See Comsource Independent Foodservice Cos. v. Union Pacific Railroad Co.*, 102 F.3d 438 (9th Cir. 1996). In *Comsource*, the defendants filed a summary judgment motion, claiming that the plaintiff's cause of action was barred by the statute of limitations. *See id.* Although the district court denied summary judgment, the parties stipulated to a final judgment for the purpose of facilitating an appeal. *See id.* As in this case, all the issues in Comsource were decided by the district court and placed in this court for de novo review. The stipulation turned a nonfinal order—the denial of a summary judgment motion—into a final judgment by virtue of an agreement between the parties and subsequent approval by the district court through an entry of judgment. *See id.* The procedure set forth in Comsource directly controls the jurisdictional question in this case.[2]

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[2] The cases of *Dannenberg* and *Cheng v. Commissioner*, 878 F.2d 306 (9th Cir. 1989), are not to the contrary. Both cases are distinguishable because they involved a district court's *grant* of partial summary judgment rather than the *denial* of summary judgment. *See Dannenberg*, 16 F.3d at 1074; *Cheng*, 878 F.2d at 308. In both *Dannenberg* and *Cheng*, the parties stipulated to a final judgment on all claims, including those that were unaffected by the district court's grant of partial summary judgment. *See Dannenberg*, 16 F.3d at 1074 (stipulating to the dismissal of all claims including a Section 11 claim arising under the Securities Act of 1933 even though it was unaffected by the grant of partial summary judgment); Cheng, 878 F.2d at 308 (stipulating to the disallowance of all of a taxpayer's claimed tax deductions even though some were left undisturbed by the district court's grant of partial summary judgment). However, the unadjudicated claims could not properly be brought on appeal. *See*

Thus, under the controlling authority of *Comsource*, we have jurisdiction over this matter pursuant to 28 U.S.C. § 1291. The scope of our review is limited to the district court's denial of summary judgment. *See Comsource*, 102 F.3d at 442.

## III.

We review a district court's denial of summary judgment de novo. *See Moran v. Washington*, 147 F.3d 839, 844 (9th Cir. 1998). On review of summary judgment, we must determine whether the evidence, when viewed in a light most favorable to the nonmoving party, raises any genuine issues of material fact and whether the district court correctly applied the substantive law. *See Berry v. Valence Tech., Inc.*, 175 F.3d 699, 703 (9th Cir. 1999). We also review de novo the district court's choice and application of the standard of review applicable to decisions of plan administrators in the ERISA context. *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 797 (9th Cir. 1997).

Due to the unusual posture in which this case has come before us, we make special note to address the parties' stipulation, which has been ratified by the district court. The parties have stipulated to the abuse of discretion standard following the district court's ruling. This stipulation was undertaken by the parties with the apparent purpose of granting finality to the ruling of the

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*Dannenberg*, 16 F.3d at 1076; *Cheng*, 878 F.2d at 310. In contrast to Comsource, the proper procedure in *Dannenberg* and *Cheng* was for the parties to obtain Rule 54(b) certification from the district court because there were undecided claims not subject to appeal. The parties in each case failed to do so, and we properly dismissed their appeals to prevent piecemeal adjudication of their claims. *See Dannenberg*, 16 F.3d at 1078; *Cheng*, 878 F.2d at 310-11.

district court on summary judgment. However, the decision of the parties to set aside issues of law does not affect the scope of our review.

As an appellate court, we are not bound by stipulations as to questions of law. *Estate of Sanford v. Commissioner of Internal Revenue*, 308 U.S. 39, 51 (1939); *Swift & Co. v. Hocking Valley Ry. Co.*, 243 U.S. 281, 289-290 (1917) (stating that a stipulation intended to be "treated as an agreement concerning the legal effect of admitted facts . . . is obviously inoperative; since the court cannot be controlled by agreement of counsel on a subsidiary question of law"). An appellate court "act[s] without any impropriety in refusing to accept what in effect [is] a stipulation on a question of law." *United States Nat'l Bank of Oregon v. Indep. Ins. Agents of Am., Inc.*, 508 U.S. 439, 448 (1993). Furthermore, the Supreme Court has stated that "a court of appeals does not abuse its discretion when it raises the validity of a law even when the parties failed to raise the issue in the briefs or before the district court." *United States v. Alameda Gateway Ltd.*, 213 F.3d 1161, 1167 (9th Cir. 2000) (citing *Nat'l Bank of Oregon*, 508 U.S. at 448).

For reasons discussed below, we set aside the parties' stipulation as to the appropriate standard of review and remand to the district court for further proceedings.

A.

Defining the proper standard of review to apply to the administrator's benefits determination is, of course, critical to determining the outcome here. The parties' stipulation is suggestive of how it might be critical, but again not dispositive on the issue of what the standard in fact should be or how it ought to be applied. Judge Brunetti hypothesizes in his dissent that, by stipulating

to an abuse of discretion standard, the parties have implicitly stipulated that the administrator's decisions were not impaired by a conflict of interest. Dissent at 13511. We reject this interpretation for several reasons. First, the record below is insufficiently developed, and the language of the stipulation insufficiently rich, for us to infer such a crucial point. Because the district court did not solicit arguments concerning the apparent existence of a conflict, the parties' views on the subject are impossible to determine. There is no indication that the stipulation was entered in order to restrict our appellate review of the facts of this case beyond the restrictions ordinarily placed on the review of a ruling on summary judgment.[3]

Second, as discussed in greater detail below, our precedent in the area of ERISA disability determinations refers to both a highly deferential and a less deferential standard of review by the same term, "abuse of discretion."[4] Precisely because the degree of deference owed to the decision maker is split within the standard according to the factual conditions under which the standard is

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[3] Rather, the statement by the parties that they wished, by entering the stipulation, "to preserve scare resources" seems to indicate only that the stipulation was intended to reduce the public and private costs of further litigation at the district court level.

[4] *See* below at Section II.B. In this sense, the term defines not an absolute degree of deference but a mode of review, meaning that we review the determination of the decision maker to ascertain its reasonableness, according to the evidence before it at the time that the determination was made, and without the benefit of hindsight. *See, e.g., Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1472 (9th Cir. 1993) (overruling a finding by the district court based on its review of evidence not before the plan administrator, because the review of such evidence under an abuse of discretion standard would lead "to the anomalous conclusion that a plan administrator abused its discretion by failing to consider evidence not before it").

to be applied, stipulation to the standard cannot be said to imply agreement as to the crucial factual predicate upon which the degree of deference turns.

Third, and diametrical to the dissent's position, we might infer from the parties' choice to place the treating physician rule at the center of this controversy that, without recourse to such a rule, the appellant would be denied even a threshold opportunity to examine the sufficiency of the Plan's reasons for terminating benefits, precisely because the Plan would be under no duty either to make their reasons specific or to base them on substantial evidence. We do not agree that this inference should guide our decision either, in part because we do not assume that the abuse of discretion standard under ERISA is necessarily incompatible with importation of the treating physician rule.

The treating physician rule applied in the Social Security setting requires that the administrative law judge ("ALJ") determining the claimant's eligibility for benefits give deference to the opinions of the claimant's treating physician, because "he is employed to cure and has a greater opportunity to know and observe the patient as an individual." *Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999); *see also Smolen v. Chater*, 80 F.3d 1273, 1285 (9th Cir. 1996). This grant of deference to a treating physician's opinions increases the accuracy of disability determinations, by forcing the ALJ who rejects those opinions to come forward with specific reasons for his decision, based on substantial evidence in the record. Just as in the Social Security context, the disputed issue in ERISA disability determinations concerns whether the facts of the beneficiary's case entitle him to benefits. Therefore, for reasons having to do with common sense as well as consistency in our review of disability determinations

where benefits are protected by federal law, we see no reason why the treating physician rule should not be used under ERISA in order to test the reasonableness of the administrator's positions.[5]

The dissent rejects this comparison on the belief that "a disability determination under ERISA is subject almost entirely to the plan's language." Dissent at 13515. The dissent further contends that adaptation of the treating physician rule to ERISA would impermissibly erode the discretion granted to a plan administrator under the terms of a lawful benefits contract. Dissent at 13515. We disagree with both of these propositions.

First, we note that the deference given to a treating physician's opinions under the rule is not absolute. "When a nontreating physician's opinion contradicts that of the treating physician—but is not based on indepen-

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[5] In deciding this issue of first impression in this circuit, we are mindful of the fact that other circuits appear divided on this issue. The only circuit explicitly to rule on the issue has held that the treating physician rule does apply to ERISA disability cases. *See Donaho v. FMC Corp.*, 74 F.3d 894, 901 (8th Cir. 1996) ("We have held, in Social Security cases, that a reviewing physician's opinion is generally accorded less deference than that of a treating physician . . . and we apply this rule in disability cases under ERISA as well.") *But see Delta Family-Care Disability & Survivorship Plan v. Marshall*, 258 F.3d 834, 842-43 (8th Cir. 2001) (distinguishing *Donaho* on the grounds that, although the record contained conflicting medical opinions regarding the beneficiary's disability, the plan administrator did not abuse its discretion by terminating benefits where that decision was supported by substantial evidence). At least one other circuit has, in dicta, expressed doubts about the rule's applicability in the ERISA disability context. *See Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607-08 (4th Cir. 1999) (concluding that it was "not persuaded" to apply the treating physician rule to the ERISA disability claim at issue, but determining that it need not reach the question because even if the rule applied, persuasive contradictory evidence existed to discount the opinion of the one treating physician who had expressed doubt as to whether the claimant could return to work).

dent clinical findings, or rests on clinical findings also considered by the treating physician—the opinion of the treating physician may be rejected only if the ALJ gives 'specific, legitimate reasons for doing so that are based on substantial evidence in the record.' " *Morgan*, 169 F.3d at 600 (quoting *Andrews v. Shalala*, 53 F.3d 1035, 1041 (9th Cir. 1995). "[I]f the treating physician['s] opinions are uncontroverted, those reasons must be clear and convincing." *Smolen*, 80 F.3d at 1285. The opinions of a nonexamining (or reviewing) physician may serve as substantial evidence under the rule, when they are supported by other evidence in the record and consistent with the evidence in the record overall. *See Shalala*, 53 F.3d at 1041. Therefore, the discretion of the plan administrator would be no more abrogated by compliance with the treating physician rule than it ought to be under a statute the purpose of which is at least in part "to promote the interests of employees and their beneficiaries." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983).

Second, we reject the view that disability determinations under ERISA are determined almost exclusively by plan language because we believe that this misstates the true role of plan language in determining our standard of review. The Supreme Court has held that our review of benefits determinations by an insurer will be for abuse of discretion when the plan language designates discretion to make such determinations and to interpret eligibility with the plan administrator. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). This ruling, however, does not indicate precisely *how* reviewing courts ought to assess the reasonableness of an administrator's determinations, only that ruling upon compliance with ERISA requires such an assessment.

Furthermore, we do not believe that the treating physician rule is inconsistent with the broad discretion accorded plan administrators under *Firestone*. Indeed, it is inaccurate to say that disability determinations under ERISA are almost entirely subject to the plan's language.[6] While this statement may be presumptively correct with respect to a plan administrator's authority to interpret the *terms* of a plan, in the context of a disability claim such as Regula's, the key issue in determining whether a claimant is entitled to benefits is not the language of the plan, but the facts of the particular case. Hence, just as in Social Security cases, the issue in dispute in this case is not the meaning of the terms of the plan but whether the facts of Regula's case entitle him to benefits. As with Social Security cases, eligibility for benefits turns almost entirely on medical professionals' opinions as to the claimant's impairments and residual capacity (*i.e.*, whether or not Regula's condition prevents him from performing "any occupation").

Like the plan administrator under ERISA, the ALJ is given broad discretion to determine eligibility for disability benefits under the Social Security Act ("SSA"). Courts review these determinations under an abuse of

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[6] *McKenzie v. General Telephone Co. of California*, 41 F.3d 1310 (9th Cir. 1994), is not to the contrary. *McKenzie* held that vocational evidence "is unnecessary where the evidence in the administrative record supports the conclusion that the claimant does not have an impairment which would prevent him from performing some identifiable job." 41 F.3d at 1317. *McKenzie* did *not* hold that vocational evidence would *never* be required, but simply that "the plan administrator is not required in *every case* where the 'any occupation' standard is applicable to collect vocational evidence in order to prove there are available occupations for the claimant." *Id.* (emphasis added). Thus, *McKenzie* does not stand for the proposition that Social Security disability cases are fundamentally different from ERISA cases or that "extraneous" terms should not be read into ERISA plans.

discretion standard, and the treating physician rule assists in this review by ensuring that the ALJ's decisions are based upon substantial evidence. It has long been settled among the circuit courts that disability determinations under SSA will be guided by the treating physician rule. *See Murray v. Heckler,* 722 F.2d 499, 501 (9th Cir. 1983) (joining the Second, Fifth, and Sixth Circuits in holding that the treating physician's opinions should be accorded greater weight than that of an examining or reviewing physician). The Social Security Administration subsequently codified the treating physician rule in its regulations governing disability determinations. *See* 20 C.F.R. §§ 404.1527(d), 416.927(d) (2001).

Under ERISA, the plan administrator is similarly charged with the task of making accurate disability determinations and those determinations are reviewable by courts in order to ensure that they are based upon appropriate and substantial evidence. *See Eley v. Boeing Co.*, 945 F.2d 276, 278 n.1 (9th Cir. 1991) (clarifying that the abuse of discretion standard under ERISA requires the plan administrator to support its decisions by "substantial evidence"). Review of the sufficiency of evidence supporting a plan administrator's disability determinations, as well as the consistency of the administrator's actions in dealing with the beneficiary, have long been a part of our review of disability determinations pursuant to the ERISA abuse of discretion standard. To the degree that the treating physician rule can assist courts to enforce the accuracy of disability determinations under ERISA, we find no reason why the rule should not be adapted to that context.

The dissent further complains that adaptation of the treating physician rule to the ERISA context is beyond our judicial authority because Congress has implicitly

excepted disability determinations under ERISA from compliance with the rule. The dissent argues that, because the rule has been codified under the Social Security Act and yet Congress failed to codify it under ERISA, congressional inaction should be interpreted as a rejection of the rule's propriety in the ERISA context. Dissent at 13515. This argument is based upon a false assessment of the genesis of both the standard of judicial review under ERISA and the treating physician rule under the Social Security Act.

In responding to the dissent, it is important to recognize that ERISA itself does not designate a particular standard for judicial review of plan administrators' disability determinations. Instead that standard was designated by the Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*, *supra*, according to its interpretation of the purposes of the statute. In *Firestone*, the Court stated that "ERISA was enacted 'to promote the interests of employees and their beneficiaries' and 'to protect contractually defined benefits.' " 489 U.S. at 113 (citation omitted) (quoting *Shaw*, 463 U.S. at 90, and *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)). It is for the latter reason that the Court adopted the abuse of discretion standard where plan language ceded discretion to the plan administrator to determine benefits and interpret contractual language. *Id.* at 115. We address the standard established by the *Firestone* decision in greater detail below. For the moment, it is most important to note that the Court's ruling was intended to reconcile the joint objectives of the statute (rather than to satisfy one to the exclusion of the other) while simultaneously interpreting the provisions of ERISA in order to maintain their consistency with"other settled principles" of law. *Id.* at 112.

Before fashioning this compromise, the Court first had to address the argument that to determine independently a standard of review was beyond its institutional authority. The petitioner *Firestone* had argued that, because Congress failed to pass a bill that would have overturned circuit court precedent applying an arbitrary and capricious standard to ERISA claims, such inaction indicated that Congress itself agreed with the application of that standard. *Id.* at 114. The Court disagreed, stating that "[t]hough 'instructive,' failure to act on the proposed bill is not conclusive of Congress' views on the appropriate standard of review." *Id.* In adjudicating between the arbitrary and capricious and de novo standards advocated by the parties, the Court concluded that the question of what standard to apply would turn partially upon plan language. It further modified this rule, in order to preserve its consistency with established principles of trust law, by stating that, even where plan language places discretion with the administrator, a conflict of interest "must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.' " *Id.* at 115 (quoting Restatement (Second) of Trusts § 187, cmt. d (1959)).

We face a similar problem in the present case. As recognized by other circuit courts, the abuse of discretion standard under ERISA has yet to be developed enough to provide a consistent, "across-the-board test" for reviewing disability determinations. *See, e.g., Donaho v. FMC Corp.*, 74 F.3d 894, 899 (8th Cir. 1996). In particular, we do not believe that ERISA dictates that the standard should lack *any* degree of specific tailoring to the task of determining disability. Moreover, we reject the argument that Social Security disability determinations are distinguished by the fact that Congress and the Social Secu-

rity Administration created an elaborate statutory and regulatory scheme governing such determinations.

In enacting ERISA, Congress also created an elaborate regime of laws and regulations governing covered benefit plans in order to protect the rights of participants and their beneficiaries. 29 U.S.C. § 1001(b) (2000). A guiding principle such as the treating physician rule that is effective in helping plan administrators make fair and accurate disability determinations is consistent with this goal. Therefore, even assuming that the Social Security scheme is somehow more "elaborate" than ERISA, that alone is insufficient reason to decline to adopt the treating physician rule.

We note that two other circuits have declined to apply the treating physician rule to ERISA health benefits determinations. *See Salley v. E.I. Dupont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992) (stating in dicta that the court has "considerable doubt about holding the [treating physician] rule applicable in ERISA cases."); *Jett v. Blue Cross & Blue Shield of Ala., Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989) (stating that even a plan's failure to contact a treating physician is not an abuse of discretion); *see also Sheppard v. Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 126 (4th Cir. 1994) (rejecting the treating physician rule when an ERISA plan is making a determination about the medical necessity of a prescribed treatment). It is worth emphasizing, however, that *Salley*, *Jett* and *Sheppard* all involved disputes over health care—rather than disability—benefits. This distinction is critical, given that the sole rationale for rejecting the rule advanced by these holdings is that a treating physician may be operating under a conflict of interest. *See, e.g.*, *Salley*, 966 F.2d at 1016 ("[T]he treating physician would stand to profit greatly if the court were to find benefits should not be terminated.") (citing

*Jett*, 890 F.2d at 1140)). Unlike health insurance benefits, which are paid directly to the treating physician, disability insurance benefits serve as a salary replacement payable to the employee. Thus, any potential conflict of interest in ERISA disability cases is no different from that which may exist in the Social Security context, where we have long found the treating physician rule to be applicable.

Indeed, far more troubling is the conflict of interest inherent when benefit plans repeatedly hire particular physicians as experts. Especially in cases such as this one, where the plan administrator is also the funding source, these experts have a clear incentive to make a finding of "not disabled" in order to save their employers money and to preserve their own consulting arrangements. None of the appellate courts deciding that the treating physician rule should not apply to health benefits determinations addressed the relevance of either potential conflict of interest.

Whereas differences exist between ERISA and Social Security in the discretion afforded plan administrators and ALJs in interpreting the terms of benefits coverage, we are not convinced that their roles differ significantly when it comes to deciding whether the facts of a particular case fall within clearly established definitions of what constitutes a disability.[7] As in the Social Security

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[7] Social Security ALJs also have broad discretion in deciding whether the facts support a finding of disability. *See Allen v. Heckler*, 749 F.2d 577, 579 (9th Cir. 1985) ("Where medical testimony is conflicting . . . it is the ALJ's role to determine credibility and to resolve the conflict."); *Allen v. Sec'y of Health & Human Servs.*, 726 F.2d 1470, 1473 (9th Cir. 1984) ("It is the ALJ's role to resolve evidentiary conflicts. If there is more than one rational interpretation of the evidence, the ALJ's conclusion must be upheld."). At the same time, as with ALJs, the discretion of plan administrators is not unfettered. For example, plan administrators are required to obtain relevant

disability context, a rule requiring plan administrators to give special weight to the opinions of treating physicians is a similarly common sense requirement that, while inconsistent with the exercise of *absolute* discretion, is perfectly consistent with the plan administrator's role in properly determining whether a particular claimant is disabled.

In the present case, given our need to remand for a determination as to whether the Delta Plan may have been operating under a conflict of interest, the scope of the plan administrator's discretionary authority may not be so broad in the first place. Given the apparent existence of a conflict, we cannot agree that the issue of what standard to apply to Delta's determination has been settled either by the parties' stipulation or by the district court's ruling. Therefore, we can make no final ruling as to whether the plan administrator abused its discretion when it terminated Regula's disability benefits. Instead, we are properly concerned with the question of whether the district court improvidently ignored evidence that was before it at the time of summary judgment and that was material to the determination of an appropriate standard of review. For reasons discussed below, we conclude that the district court erred in this regard, and we remand for a proper determination as to the administrator's impairment due to a conflict of interest.

B.

We review de novo the decision of a plan administrator to deny benefits "unless the benefit plan gives the

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medical evidence to guide their decisions. *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1015 (5th Cir. 1992) (holding that the plan administrator abused its discretion by failing to obtain necessary medical information).

administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone*, 489 U.S. at 115; *see also Tremain v. Bell Industries, Inc.*, 196 F.3d 970 (9th Cir. 1999). When the plan's language confers such discretion, we review the decision of the administrator under an abuse of discretion standard. *Tremain*, 196 F.3d at 976.

In this case, the Plan's language appears to grant the Administrative Committee the broadest possible discretion in determining benefits eligibility:

> The Administrative Committee shall have the broadest discretionary authority permitted under the law in the exercise of all its functions, including, but not limited to, deciding questions of eligibility, interpretation, and the right to benefits hereunder but shall act in an impartial and non-discriminatory manner with respect thereto.

The Administrative Committee also has "the exclusive power to interpret" the Plan and "its interpretation and decisions [are] final and conclusive." Finally, the Administrative Committee is empowered to "decide all questions concerning the Plan."

Nevertheless, the fact that the terms of the Plan vest the administrator with broad discretionary authority does not end our inquiry. In *Firestone*, the Supreme Court ruled that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.' " *Id.* at 115; *see also Snow v. Standard Ins. Co.*, 87 F.3d 327, 331 (9th Cir. 1996). We have held that our review in such cases is "still for abuse of discretion, [but it] is 'less deferential.' " *Tremain*, 196 F.3d at 976.

At the time of its ruling, the district court had before it Plan documents indicating that all of the members of the Administrative Committee were appointed by the Delta Board of Directors. Furthermore, although the benefit fund was organized as a trust, it was funded exclusively by Delta companies based on actuarial data. Thus, Delta effectively acted as both administrator and funding source for the Plan.

These factors formed the basis of our decision in *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Technology, Inc.*, *supra*, where we held that an insurer's "conflict of interest, arising out of its dual role as the administrator and funding source for the Plan, affected its decision in Lang's case." *Id.* at 796; *see also Tremain*, 196 F.3d at 976-77 (finding a conflict of interest under similar circumstances). The *Lang* court approvingly cited the Eleventh Circuit's decision in *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991), for the proposition that "plans such as this one, funded by insurers and also administered by them, are not true trusts." *Lang*, 125 F.3d at 798 (citing *Brown*, 898 F.2d at 1567); *see also Doe v. Group Hosp. & Med. Servs.*, 3 F.3d 80, 86-87 (4th Cir. 1993) ("Even the most careful and sensitive fiduciary [when operating under a conflict of interest] may unconsciously favor its profit interest over the interests of the plan, leaving beneficiaries less protected than when the trustee acts without self-interest and solely for the benefit of the plan."). Under such circumstances, plan benefits decisions are subject to a less deferential standard of review.

This "less deferential" standard consists of two steps:

> First, we must determine whether the affected beneficiary has provided material, probative evidence, beyond the mere fact of the apparent conflict, tend-

> ing to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary. If not, we apply our traditional abuse of discretion review. On the other hand, if the beneficiary has made the required showing, the principles of trust law require us to act very skeptically in deferring to the discretion of an administrator who appears to have committed a breach of fiduciary duty.

*Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995). By providing material, probative evidence of a conflict, the plan beneficiary creates a rebuttable presumption that the plan's decision was in fact a dereliction of its fiduciary responsibilities. The plan then "bears the burden of rebutting the presumption by producing evidence to show that the conflict of interest did not affect its decision to deny or terminate benefits." *Lang*, 125 F.3d at 798. If the plan fails to carry its burden, then we review de novo its decision denying benefits. *Tremain*, 196 F.3d at 976.

Because in this case Delta acted as both administrator and funding source for the plan, and evidence of this conflict was before the district court at the time of summary judgment, the district court should have determined whether the apparent conflict of interest was indeed serious enough to have resulted in a breach of fiduciary duty before choosing the appropriate standard of review to be applied to the Plan's disability determinations. Thus, the court erred in failing even to consider whether Regula provided or could provide material, probative evidence of a breach of fiduciary duty. Instead the court simply concluded from the language of the Plan that an abuse of discretion standard applied, and then permitted the parties to enter into a stipulation presuming that this highly deferential standard was incontro-

vertibly the appropriate standard of review. *Cf. Lang*, 125 F.3d at 799-800 ("The district court did not conduct the appropriate conflict of interest analysis and hence accorded [the insurer] a deference to which it was not entitled.") This conclusion was premature, and, as a result, this case has arrived for our review with an extremely unusual and infelicitous posture.

C.

We stated at the outset that, if the district court proceedings had not been curtailed by the parties' stipulation, we may well have been able to determine the proper standard for the judicial review of the Plan's termination of Regula's disability benefits. However, under the present posture, such a determination by this court would be both premature and prejudicial, since the judicial assessment of an apparent conflict is managed through a burden-shifting scheme and the parties in this case, while presenting some relevant evidence for our review, have not been permitted the opportunity to make thoroughly responsive arguments regarding the fulfillment of their burdens. Still, we do not conclude that the district court must restart this process from scratch.

As stated above, a plan will be viewed as operating under an apparent conflict when it is both funded and administered by the insurer. In the present case, Delta both funds and administers the Plan. However, de novo review of a plan that gives discretion to an administrator remains inappropriate unless the plan beneficiary comes forward with material, probative evidence "tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." *Atwood*, 45 F.3d at 1323.

In *Lang*, we ruled that evidence of inconsistency in the administrator's dealings with the beneficiary was material evidence of its self-interested behavior and grounds for ultimately reinstating benefits. The evidence of inconsistency in that case regarded a series of events in which the defendant plan first denied disability benefits because the beneficiary lacked evidence of a physical ailment and later, when confronted with an uncontroverted diagnosis by her treating physician that the beneficiary had fibromyalgia, continued to withhold benefits pending proof that the physical ailment alone was the cause of her disability. 125 F.3d at 799; *see also Brown*, 898 F.2d at 1569 (finding evidence of inconsistency in the administrator's reversal of a payment decision for only one of two related claims on the basis of no new evidence). In *Tremain v. Bell Industries*, *supra*, we held that a plaintiff beneficiary established material, probative evidence of a conflict of interest where the plan administrator appeared to have relied upon an improper definition of disability in processing the beneficiary's claim and where the administrator announced a determination of the beneficiary's earning capacity for which it provided no supporting evidence. 196 F.3d at 977.

Here, we find a similarly unsettling pattern of inconsistency and insufficiency in the plan administrator's reasons for terminating the appellant's benefits. First, the Plan's sudden termination of Regula's benefits came abruptly, with no evidence alleged of a significant change in his condition. This point is significant because the Plan had otherwise maintained the appellant's long-term benefits for almost eight consecutive years, while reviewing his claim regularly at three month intervals. Second, and more importantly, once Regula appealed the Plan's decision, the Plan based its final determination upon reports provided by examining physicians whose

diagnoses contradicted those of Regula's own treating physicians and to whom Regula had been referred by the Plan in response to the medical reports that Regula produced during his appeal. We note that the plan's examining doctors contradicted the treating physicians on issues that the latter themselves had considered, and (with the single exception of the criticism made about Dr. Smith's expertise) without providing specific reasons for their disagreement.

We cannot find that the Plan's sudden and thinly supported departure from the prevailing diagnosis offered by Regula's doctors was either consistent or sufficiently supported by the record. Furthermore, we find that, in light of the Plan's apparent conflict of interest, the administrator's decision to reject the opinions of the appellant's treating physicians constitutes material, probative evidence of a conflict. On this point, we add deviation from the treating physician rule to the short list of factors by which a court may determine that an apparent conflict of interest has ripened into an actual, serious conflict, thereby permitting the court to engage in de novo review. Of course, the Plan could rebut this evidence by showing that its termination decision was supported by specific, legitimate reasons that are based on substantial evidence in the record. In this sense, our ruling resembles the treating physician doctrine found in the Social Security context. *Cf. Morgan*, 169 F.3d at 600. However, because the district court concluded that the treating physician rule did not apply in the ERISA context, it did not provide the parties with an opportunity to complete this burden-shifting analysis.

We conclude that the proper standard of review to be applied to the plan administrator's decision in this case can only be determined after an appropriate determination has been made in the district court regarding the

Plan's apparent compromise due to a conflict of interest. Therefore, we remand to the district court for a proper finding on this issue. On remand, we direct the district court to receive and consider additional evidence regarding Delta's apparent conflict of interest, so as "to enable the full exercise of informed and independent judgment." *Mongeluzo v. Baxter Travenol Long Term Disability Ben. Plan*, 46 F.3d 938, 943 (9th Cir. 1995). When examining the evidence for a conflict of interest, the district court is not limited to the administrative record before the plan administrator at the time that the benefits determination was made. *Tremain*, 196 F.3d at 977. In addition, we note that, since we have already determined by our own review of summary judgment that the appellant did establish material, probative evidence of a conflict, the burden now falls upon the Plan to rebut the presumption that it was acting under a conflict.

**VACATED AND REMANDED.**

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BRUNETTI, Senior Circuit Judge, dissenting:

I dissent from part III of the majority's opinion.

## I.

In this case, the district court reviewed the decision terminating Regula's disability benefits, by Delta's ERISA Plan Administrator, for an abuse of discretion. The abuse of discretion standard was applied for good reason—the parties stipulated to this standard of review. Nowhere in the briefs does either party argue that a different standard should apply. In fact, Regula's opening

brief states that "Plaintiff conceded in the District Court that it reviews factual determinations for abuse of discretion." Opening Brief at 11. The parties' stipulation is in complete accord with the Plan's language, which states that:

> The Administrative Committee shall have the broadest discretionary authority permitted under the law in the exercise of all its functions, including, but not limited to, deciding questions of eligibility, interpretation, and the right to benefits hereunder but shall act in an impartial and non-discriminatory manner with respect thereto.

The Administrative Committee is also granted "the exclusive power to interpret" the Plan, its interpretation and decisions being "final and conclusive." However, the majority now holds that before applying this standard of review in accordance with the stipulation, the district court should have determined whether the Plan was operating under a conflict of interest.

There is no doubt that where a conflict of interest is found to exist, the plan administrator's decision is afforded less deference. *See Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989); *Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 976 (9th Cir. 1999). But that is not the factual record in this case. Regula made no such claim, offered no such proof, and has stated to the contrary by stipulation to the abuse of discretion standard of review. *See Atwood v. Newmont Gold Co.*, Inc., 45 F.3d 1317, 1323-23 (9th Cir. 1995) ("We ultimately apply a traditional abuse of discretion standard to the decisions of apparently conflicted employer- or insurer-fiduciaries *unless* the affected beneficiary comes forward with further evidence indicating that the conflicting interest caused a breach of the administrator's fiduciary

duty to the beneficiary."). The majority opinion has reached out and created a new case for Regula that never existed. I do not agree with the majority's determination that although the parties' stipulation to abuse of discretion review acts as a waiver, this court is under an obligation to, sua sponte, order an evidentiary hearing to *see* whether there was indeed a conflict of interest.

The majority cites *Estate of Sanford v. Comm'r of Internal Revenue*, 308 U.S. 39 (1939) and *U.S. v. Alameda Gateway Ltd.*, 213 F.3d 1161 (9th Cir. 2000) for the proposition that we are not bound to accept the parties' stipulation as to the abuse of discretion standard. I disagree. In *Estate of Sanford*, 308 U.S. at 50, the parties stipulated to an interpretation of the gift taxing *statutes* at issue. The Supreme Court refused to be bound by the stipulation, holding that "[w]e are not bound to accept, as controlling, stipulations as to questions of law." *Id.* at 51. In *Alameda Gateway Ltd.*, in the context of noncompliance with an agency statement that was not binding on the agency, this court stated that "the Supreme Court has recognized that a court of appeals does not abuse its discretion when it raises the validity of a law even when the parties failed to raise the issue in the briefs or before the district court. *See id.* at 1167 (citations omitted). This Court observed that the Supreme Court carved out an exception to the general rule of waiver, stating 'that the Court of Appeals acted without any impropriety in refusing to accept what in effect was a stipulation on a question of law.' " *See id.* (citing *United States Nat'l Bank of Oregon v. Independent Ins. Agents of Am.*, 508 U.S. 439, 448 (1993). Notably, this exception was applied where we found ourselves with the "unsavory prospect of *reviewing a regulation* that may not have the force of law and which our case law specifically precludes us from reviewing." *See*

*id.* at 1168 (emphasis added). Furthermore, in *United States Nat'l Bank of Oregon*, 508 U.S. at 447-48, cited by this court in *Alameda Gateway Ltd.*, 213 F.3d at 1167-68, the Supreme Court held that the court of appeals had a duty to, sua sponte, inquire into the validity of a *statute* that had thought to have been repealed. What all of these cases have in common is that through stipulation or waiver, federal courts found themselves in the precarious position of possibly having to *apply a law* or an *interpretation of a law* that by its very nature is invalid.

Our situation is different because the parties did not stipulate to a question of law in its ordinary sense. No one is arguing here that a law is invalid or that a particular meaning should be given to the phrase "abuse of discretion." Rather, the parties stipulated to a *standard of review*, which, unlike the cases mentioned, had the effect of waiving questions of fact, not a question of law. The parties could have stipulated before the district court that the Plan Administrator was not operating under a conflict of interest, a factual determination. This, together with the indisputably broad discretionary power granted to the Plan Administrator, would have unquestionably resulted in an abuse of discretion standard of review. By stipulating, instead, to the abuse of discretion standard of review, the parties have implicitly stipulated to the question of fact that the Plan Administrator was not operating under a conflict of interest. Regula has never argued or set forth a contrary position at any point in the proceedings, including his briefs to this Court. *See Atwood*, 45 F.3d at 1323-23. Thus, I believe that the district court correctly applied the abuse of discretion standard.

## II.

### A.

Reviewing the Plan Administrator's decision for an abuse of discretion, I would affirm the district court. Regula first contends that the Plan abused its discretion as a matter of law because it failed to consider vocational evidence in evaluating Regula's claim. However, under the "any occupation" standard, the "consideration of vocational evidence is unnecessary where the evidence in the administrative record supports the conclusion that the claimant does not have an impairment which would prevent him from performing some identifiable job." *McKenzie v. General Tel. Co. of California*, 41 F.3d 1310, 1317 (9th Cir. 1994). Long-term disability determinations are made according to the "any occupation" standard under the Delta Plan. Thus, under *McKenzie*, it was unnecessary for the Plan to identify specific jobs within Regula's specifications in order to reject his claim.

There is ample evidence in the record to support the Administrative Committee's conclusion that Regula could perform some occupation. As the district court pointed out, "the Plan relied upon the reports of Dr. Kumar, which detailed the restrictions on Plaintiff's ability to work, and Dr. O'Brien who opined that 'there is no type of work within [Regula's] job description that he would not be able to do.' " Thus, while the Administrative Committee did not rely on vocational evidence that specifically identified potential jobs for Regula, because it was not required to do so under *McKenzie*, the evidence in the record indicates that Regula does not have an impairment that prevents him from performing "some identifiable job."

**B.**

Regula has asked, and the majority has agreed, to import the "treating physician rule" from Social Security disability cases for application to disability determinations under ERISA. I disagree with this holding. The treating physician rule, as applied in Social Security cases, requires that greater, though not conclusive, weight be placed on the opinion of a treating physician. *See Magallanes v. Bowen*, 881 F.2d 747, 751 (9th Cir. 1989). Under the rule, specific reasons based on substantial evidence must support the rejection of a treating physician's opinion. *See Embrey v. Bowen*, 849 F.2d 418, 421 (9th Cir. 1988). I would reject the application of the treating physician rule in ERISA cases because there are significant differences between Social Security and ERISA that counsel against adoption of the rule in the ERISA arena.

Congress and the Social Security Administration ("SSA") have created an elaborate statutory and regulatory scheme governing Social Security disability determinations. *See* 42 U.S.C. §§ 401-433; 20 C.F.R. §§ 404.1-.2127, 416.101-.2227. For instance, the SSA has created a detailed five-step procedure to evaluate which claimants are disabled and therefore entitled to Disability Insurance benefits. *See* 20 C.F.R. § 404.1520, 416.920; *see also Cleveland v. Policy Mgmt. Sys. Corp.*, 526 U.S. 795, 804 (1999) (describing the SSA's fivestep evaluation process). As part of this sequential procedure, the SSA has created grids to provide guidance about whether a claimant is disabled. *See* 20 C.F.R. § 404, Subpart P, Appendix 1-2; *Reddick v. Chater*, 157 F.3d 715, 729 (9th Cir. 1998). The SSA has also codified the treating physician rule in the regulations governing disability determinations. *See* 20 C.F.R. §§ 404.1527(d);

416.927(d). Thus, although this Court reviews Social Security benefits eligibility determinations made by an Administrative Law Judge ("ALJ") for substantial evidence and application of the correct legal standards (similar to the ERISA context), *see Flaten v. Sec'y of Health & Human Servs.*, 44 F.3d 1453, 1457 (9th Cir. 1995), an ALJ must follow far stricter guidelines (such as detailed grids) than a plan administrator making the same determination under ERISA.

In contrast to Social Security, a disability determination under ERISA is subject almost entirely to the plan's language. *See Firestone*, 489 U.S. at 115 ("[T]he validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of terms in the plan at issue."); *Bendixen v. Standard Ins. Co.*, 185 F.3d 939, 944 (9th Cir. 1999) (stating that an ERISA plan abuses its discretion when it deviates from the language of the plan). Whereas Social Security sets forth a very elaborate statutory and regulatory scheme, the ERISA implementing regulations only specify minimum requirements for the consideration of claims, *see* 29 C.F.R. § 2560.503-1, and do not mention whether the treating physician rule should apply under ERISA.

Because of the differences between Social Security and ERISA, the treating physician rule should not apply in ERISA cases unless the plan's language dictates such a rule. There is no such provision in this case. Accordingly, this Court should not interfere with the contractual terms agreed upon by an employee and employer in forming an ERISA plan. In addition, neither Congress nor the Department of Labor have seen fit to include the treating physician rule within the statutory or regulatory scheme governing ERISA. Thus, unless there is a provision in an ERISA plan that calls for the application of the treating physician rule, we should decline to adopt

such a rule as part of the federal common law. This result is consistent with the general view that ERISA should be governed primarily by the language of the plan, and not by an elaborate statutory and regulatory scheme such as that governing Social Security.

As an illustration of the emphasis placed on the language of an ERISA plan, this Court has previously rejected the need for vocational evidence when a plan's language subjects the claimant's eligibility for disability benefits to the "any occupation" standard. *See McKenzie*, 41 F.3d at 1317. The vocational evidence requirement originates from the regulations governing Social Security disability determinations. *See* 42 U.S.C. § 423(d)(2)(A); 20 C.F.R. §§ 404.1520(f), 416.920(f). Under step five of the SSA's sequential evaluation procedure, the ALJ bears the burden to show that there are jobs that the claimant can perform (*i.e.* it requires consideration of vocational evidence). *See Smolen v. Chater*, 80 F.3d 1273, 1291 (9th Cir. 1996). However, under almost identical circumstances, this Court rejected the importation of the vocational evidence rule into ERISA cases when the plain language of the plan does not require the consideration of such evidence. *See McKenzie*, 41 F.3d at 1317. Thus, this Court's rule that vocational evidence is unnecessary in ERISA cases, even though it is required in Social Security cases, supports the conclusion that this Court should not read extraneous terms into an ERISA plan.

This result is also consistent with the broad discretion conferred on plan administrators under *Firestone*. The Supreme Court stated in *Firestone* that a plan granting an administrator broad discretion over eligibility determinations should be accorded deference by limiting a court's review of those decisions to an abuse of discretion standard. *See Firestone*, 489 U.S. at 115. A rule that

requires plan administrators to consider certain types of evidence and to weigh that evidence in a compulsory manner would effectively undermine that discretion. *See Dowden v. Blue Cross & Blue Shield of Texas, Inc.*, 126 F.3d 641, 644 (5th Cir. 1997) (recognizing that in determining medical necessity under an ERISA plan, granting "conclusive weight to the opinion of the attending physician would vitiate the discretionary authority expressly granted to [the plan] in the contract."). A plan administrator should be entitled to the same deference it receives on other decisions when it considers how much emphasis to place on the opinion of a treating physician.

Of the four other Circuits that have considered whether the treating physician rule should apply in ERISA cases, three have rejected the rule's application under ERISA. *See Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 126 (4th Cir. 1994) (rejecting the treating physician rule when an ERISA plan is making a determination about the medical necessity of a prescribed treatment); *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992) (stating in dicta that the court has "considerable doubt about holding the [treating physician rule] applicable in ERISA cases."); *Jett v. Blue Cross & Blue Shield of Alabama, Inc.*, 890 F.2d 1137, 1139-40 (11th Cir. 1989) (stating that even a plan's failure to contact a treating physician is not an abuse of discretion). In a recent case, the Fourth Circuit suggested that the treating physician rule is not only inapplicable when determining medical necessity in accordance with *Sheppard*, but that it was not persuaded to apply it to disability determinations either. *See Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607 (4th Cir. 1999). Furthermore, although the fourth case, *Donaho v. FMC Corp.*, 74 F.3d 894, 901 (8th Cir. 1996), appears to support the majority's application of the treat-

ing physician rule in ERISA cases, subsequent Eighth Circuit case law has drastically undercut its precedential effect. *See Delta Family-Care Disability and Survivorship Plan v. Marshall*, Nos. 00-3441 & 00-3923, 2001 WL 856270, at *6 (8th Cir. July 31, 2001) (stating that although a reviewing physician's opinion is generally accorded less deference than that of a treating physician in reviewing disability cases under ERISA, "a treating physician's opinion does 'not automatically control, since the record must be evaluated as a whole.' "); *Fletcher-Merrit v. Noram Energy Corp.*, 250 F.3d 1174, 1180 n.3 (8th Cir. 2001). Both cases emphasize the extreme circumstances at play in *Donaho* in which two treating physicians and an examining physician contradicted the reviewing physician's conclusions. *See Delta Family-Care*, 2001 WL 856270 at *6; *Fletcher-Merrit*, 250 F.3d at 1180 n.3.

Of particular note, *Jett* and *Salley* recognize that the treating physician rule creates an inherent conflict of interest that encourages treating physicians to continue to treat their patients as disabled. *See Salley*, 966 F.2d at 1016; *Jett*, 890 F.2d at 1140. An illegitimate conflict exists in ERISA cases because "the treating physician would stand to profit greatly if the court were to find benefits should not be terminated." *Salley*, 966 F.2d at 1016. Because an ERISA plan ordinarily requires a claimant to reprove their disability periodically, a disability finding by a treating physician almost guarantees another visit by that claimant. Thus, the rule creates an inherent conflict of interest in the ERISA context that justifies a decision not to place special weight on the opinion of a treating physician. These out-of-circuit cases and their respective rationales provide further support for the conclusion that the treating physician rule should not apply to ERISA cases.

## C.

Regula argues that the district court's decision to deny summary judgment was erroneous because the Plan abused its discretion as a matter of law. Specifically, Regula asserts that the Plan was required to make a finding that Regula's condition had improved before terminating his benefits. However, the plan states that a beneficiary is entitled to benefits "so long as he remains disabled." Therefore, according to the plain language of the plan, a determination that Regula was no longer disabled would justify a termination of his benefits. The Plan did not abuse its discretion in terminating his benefits because the Plan's finding that Regula was no longer disabled is supported by substantial evidence in the record and was based on a reasonable interpretation of the plan's terms. *See Hancock v. Montgomery Ward Long Term Disability Trust*, 787 F.2d 1302, 1307 (9th Cir. 1986).

For Regula to prevail on appeal, he must show that the Plan abused its discretion when it denied his benefits."It is an abuse of discretion for an ERISA plan administrator to make a decision without any explanation, or in a way that conflicts with the plain language of the plan, or that is based on clearly erroneous findings of fact." *Atwood*, 45 F.3d 1323-24. This Court should affirm the plan administrator's decision if it was based upon substantial evidence and complied with the terms of the plan. *See, e.g., Meditrust Fin. Servs. Corp. v. The Sterling Chemicals, Inc.*, 168 F.3d 211, 215 (5th Cir. 1999); *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 232 (4th Cir. 1997). Substantial evidence does not mean that the plan administrator's decision must be proven correct by a preponderance of the evidence. Rather, substantial evidence "is such relevant evidence as reasonable minds

might accept as adequate to support a conclusion even if it is possible to draw two inconsistent conclusions from the evidence." *Gilbrook v. City of Westminster*, 177 F.3d 839, 856 (9th Cir. 1999).

The Plan relied on the detailed reports of Drs. O'Brien and Kumar, who were hired by the Plan to independently assess whether Regula was still disabled. Dr. Kumar opined in a detailed eight-page report that Regula "is definitely [physically] capable of gainful employment performing some type of work." Furthermore, Kumar's report specified Regula's physical limitations and consequently concluded that he could work based on those specifications.

In contrast, most of Regula's evidence was superannuated by the time the Plan terminated his benefits. With the exception of the report by Dr. Dean Cummings, all of Regula's evidence was submitted prior to March 3, 1993, approximately two years prior to the termination of his benefits. Although Cummings' report clearly states that Regula was still permanently disabled on December 5, 1994, it was not an abuse of discretion, as a matter of law, for the Plan to reject his opinion and accept Kumar's more recent report.

Regula also argues that it was an abuse of discretion for the Plan to ignore the report submitted by his treating physician, Dr. Smith, stating that Regula's combined physical and psychological symptoms rendered him permanently disabled. This argument is without merit for two reasons. First, the Plan relied on an independent opinion submitted by Dr. O'Brien, in which he found that "Mr. Regula can return to work immediately and that there is no type of work within his job description that he would not be able to do." O'Brien's report further stated that Regula was a "malingerer" who was "consciously exaggerating his psychological and ortho-

pedic difficulties." Second, it was reasonable for the Plan to conclude that Smith's reports were less probative due to the perceived inconsistencies in her report and O'Brien's opinion that Smith might have been biased. In fact, the letter sent to Regula explaining the Administrative Committee's decision indicates that it found O'Brien's opinion more persuasive and expressed concerns about Smith's lack of objectivity based on comments she made outside of her field of expertise.

Because the Plan's decision is supported by substantial evidence, is consistent with the language of the plan, and there is no showing of clearly erroneous findings of fact, I believe that the district court correctly concluded that the Plan did not abuse its discretion as a matter of law.

## III.

I also believe that the district court did not err when it found that the Plan had met the requirements of "full and fair review." Regula alleges that the Plan failed to fully comply with several technical notice requirements set forth in the regulations governing ERISA. *See* 29 C.F.R. § 2560.503-1(f). In particular, Regula contends that the Plan failed to include the following requisite information in its denial letter: (1) a specific reason for the denial; (2) a specific plan provision supporting the denial; and (3) specificity regarding how Regula could perfect his claim. The Plan did provide Regula with a "full and fair review" of his claim, however, because it substantially complied with ERISA's notice requirements. *See Terry v. Bayer Corp.*, 145 F.3d 28, 38-39 (1st Cir. 1998); *Dade v. Sherwin-Williams Co.*, 128 F.3d 1135, 1141 (7th Cir. 1997).

ERISA requires that employers must "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133. The Department of Labor has further specified that adequate notice requires that the plan give a specific reason for its denial, refer to a specific plan provision on which its denial is based, provide information about how the claimant can perfect his claim, and inform the claimant about how to submit his claim for further review. *See* 29 C.F.R. § 2560.503-1(f). These notice requirements are designed to provide "a meaningful dialogue between ERISA plan administrators and their beneficiaries." *Boyd v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). Adequate notice is required to allow beneficiaries to adequately prepare for further administrative review, as well as for an appeal in federal court. *See Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388, 394 (5th Cir. 1998). Thus, the underlying question is whether the Plan's initial denial letter afforded Regula the necessary notice allowing him to seek further review of his claim. *See Dade*, 128 F.3d at 1142.

The Plan's letter referred to the relevant plan provisions and provided specific reasons for the denial. The letter indicated that the Plan exclusively relied upon the independent medical reports submitted by Drs. Kumar and O'Brien in denying his claim. The letter specifically informed Regula that both doctors concluded that he was "able to do some type of work," justifying the Plan's conclusion that Regula was no longer disabled. In addition, the letter also referenced the specific provision in the plan that supported the denial—the letter explained that Regula's condition no longer met the definition of long-term disability found in Section 4.03 of the plan.

Where, as here, a denial letter cites to a specific plan provision and the relevant physician reports support the denial, a plan has met the notice requirements of § 2560.503(f)(1)-(2). *See Collins v. Cent. States, Southeast and Southwest Areas Health and Welfare Fund*, 18 F.3d 556, 561 (8th Cir. 1994).

The Plan also provided Regula with the necessary information to perfect his claim. *See* 29 C.F.R. § 2560.503-1(f)(3). In its denial letter, the Plan notified Regula that in order to perfect his claim, he "must establish by objective evidence that [he is] continuously and totally disabled from engaging in any occupation or work for compensation or profit." In many situations, a plan is uncertain about what types of additional evidence might perfect a claim. For example, in *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1091 (9th Cir. 1998) (en banc), this Court recognized that there are situations when a plan does not need to inform a claimant about how to perfect his claim because additional evidence would not change the outcome. Regula did, in fact, submit additional objective evidence, which the Plan found unpersuasive. The notice provided by the Plan and the Plan's request for "additional objective evidence" substantially complied with the ERISA notice requirements.

Regula also argues that the denial letter sent by the Administrative Subcommittee after his first appeal did not contain instructions regarding how he could perfect his appeal. However, it is unnecessary for a denial letter following an appeal to provide information about how a claimant can perfect his claim. *See* 29 C.F.R. § 2560.503-1(h)(3).

He further contends that a letter sent by the Plan that purportedly cured any defects in the earlier denial letter arrived only six days prior to his final appeal to the Administrative Committee, thereby arriving too late to

be of any assistance. However, this contention has no merit because the earlier letter did meet the notice requirements, rendering consideration of that final letter unnecessary.

Regula's final contention on appeal is that the Plan failed to provide him with a full and fair review because it did not afford him sufficient time to comment on and review pertinent documents prior to his final appeal to the Administrative Committee. Under 29 C.F.R. § 2560.503-1(g)(1), an ERISA plan must allow a claimant to "[r]eview pertinent documents" and "[s]ubmit issues and comments in writing." *Id.* This requirement means that a benefit plan must "provide claimants with access to 'the evidence the decisionmaker relied upon' in denying their claim." *Wilczynski v. Lumbermens Mutual Cas. Co.*, 93 F.3d 397, 402 (7th Cir. 1996). A benefit plan does not need to allow a claimant to review every document in his administrative file, but only those documents that are influential in the plan's decision. *See id.* By Regula's own admission, his attorney was able to review and comment upon the reports provided by Drs. Kumar and O'Brien, which the Plan relied on exclusively in denying Regula's claim. Therefore, although Regula may not have inspected all the information in his administrative file, he was able to examine and comment upon all the information that formed the basis for the denial of his claim.

The Plan did not deny Regula a full and fair review of his claim because the Plan substantially complied with the procedural requirements found in ERISA's implementing regulations. *See* 29 C.F.R. § 2560.503-1.

## IV.

For these reasons, I respectfully dissent. The judgment of the district court should be affirmed.

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

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Case No. CV 96-7304 RSWL(VAPx)
Filed February 17, 1998

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FRANK REGULA,

*Plaintiff*,

—v.—

DELTA FAMILY-CARE DISABILITY AND SURVIVORSHIP PLAN,

*Defendant*.

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ORDER DENYING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

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## I.

## INTRODUCTION

This action arises out of Plaintiff Frank Regula's ("Plaintiff") claim that Defendant Delta Family-Care Disability and Survivorship Plan ("the Plan") deprived him of disability benefits owed him by the Plan. Plaintiff filed this action on October 17, 1996, seeking declaratory relief and benefits under the Plan.

Plaintiff now moves for summary judgment pursuant to Federal Rule of Civil Procedure 56, on the grounds

that there is no genuine issue as to any material fact and Federal Express is entitled to judgment as a matter of law. This Motion was set for oral argument on October 20, 1997, but was removed from the Court's law and motions calendar pursuant to Federal Rule of Civil Procedure 78 for disposition based on the papers filed.

After carefully reviewing the papers submitted in support of and in opposition to the Motion, the Court hereby **DENIES** Plaintiff's Motion for Summary Judgment.

## II.

## BACKGROUND

The Plan is a welfare benefit plan governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan provides short and long term disability benefits to employees of Delta Air Lines, Inc. ("Delta") under specified conditions.

The Plan is administered by the Plan's Administrative Committee (the "Administrative Committee"), which is granted full discretion to decide all claims for benefits and to review the appeals of benefit claims. A participating Delta employee may qualify for short term disability benefits under the Plan Documents[1] "when disabled as a result of a demonstrable injury or disease . . . which prevents [him] from engaging in [his] customary occupation." (Compl., Ex. 1 at 24.) Upon expiration of his short term disability, the employee may qualify for long term disability if he demonstrates that he is "disabled at that time as a result of demonstrable injury or disease . . . which will continuously and

[1] "Plan Documents" refers to the Document entitled "Delta Family-Care Disability and Survivorship Plan (As Amended and Restated Effective January 1, 1994)."

totally prevent him from engaging in any occupation whatsoever for compensation or profit, including part-time work." (Compl., Ex. 1 at 25.) Once a participant begins receiving disability benefits under the Plan, his status is regularly reviewed in order to determine whether he remains qualified to receive those benefits.

If a participant's claim for disability is denied, he is entitled to two levels of internal review. First, the participant must appeal the denial to the Plan's Administrative Subcommittee. (Compl., Ex. 1 at 42.) If the participant is not satisfied with the determination made by the Subcommittee, he may appeal the Subcommittee's determination to the Administrative Committee. (Compl., Ex. 1 at 42, 43.)

Plaintiff worked as a clerk for Delta. As an employee, Plaintiff was a participant in the Plan. On September 15, 1987, Plaintiff filed a claim for short term disability benefits, claiming that he had sustained a "cervical disc injury."[2] (A.R. DEL1000.) Based on Plaintiff's claim of injury and supporting physician statements, the Plan awarded Plaintiff short term disability benefits through October 30, 1987. On November 11, 1987, Plaintiff applied for long term disability benefits. The Plan approved long term disability benefits for Plaintiff for an initial period between October 31, 1987, and January 31, 1988. On several occasions thereafter, the Plan extended Plaintiff's long term disability benefits based upon medical reports it received from Plaintiff's treating physicians regarding Plaintiff's condition.[3]

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[2] In addition to his cervical injury, Plaintiff later developed recurrent abdominal pain, depression and anxiety.

[3] The physicians who examined Plaintiff during this period include Michael Smith, MD, H. Dale Richardson, MD, Peter Schou, PhD, Alfred Bloch, MD, PhD, Burton Wixen, MD, Sandra Smith, PhD, and Dean H. Cummings, D.C.

In a report dated August 1, 1994, Dr. Sandra Smith, one of Plaintiff's treating physicians, indicated that it was unknown whether Plaintiff would continuously be unable to work in any occupation, and that, with appropriate vocational rehabilitation services, Plaintiff might be able to engage in some part-time work in six to twelve months. (A.R. DEL1169.) Thereafter, the Plan requested additional information from Dr. Smith regarding the likelihood that Plaintiff might be able to work in six to twelve months with rehabilitation services. In response, Dr. Smith indicated that Plaintiff's "combined physical and emotional symptom complex" prevented him from enrolling in a vocational rehabilitation program. (A.R. DEL1171-73.)

In a letter dated December 22, 1994, the Plan arranged for Plaintiff to be examined by Dr. Rajeswari Kumar, an independent orthopedic medical examiner. (A.R. DEL1177-78) Dr. Kumar was asked to provide an opinion as to whether Plaintiff was able to perform some type of work and, if so, to identify what type of work he was able to perform. After examining Plaintiff, Dr. Kumar reported: "I believe the patient is definitely capable of gainful employment performing some type of work." (A.R. DEL1186.)[4] In response to Dr. Kumar's report, Dr. Smith stated that she "found Dr. Kumar's

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[4] More specifically, Dr. Kumar stated that Plaintiff is "capable of performing tasks limited to lifting 25 pounds occasionally and 15 pounds frequently. Standing and walking can be done up to four to six hours per day. His sitting tolerance is six hours per day. Pushing and pulling are limited to the same amounts as lifting. He is able to bend, squat and crawl occasionally, climb frequently and work in unprotected heights. There is no limitation reaching above the shoulder level with both upper extremities, using the feet for repetitive movements as in operating foot controls, using both hands for repetitive simple grasping, pushing and pulling and fine manipulating." (A.R DEL1186.)

description of [Plaintiff's] abilities to be absolutely inconceivable." (A.R. DEL1189.) She further noted that notwithstanding Dr. Kumar's report as to Plaintiff's physical condition, Plaintiff's psychological condition prevented him from returning to work. (A.R. DEL1188.)

Thereafter, the Plan arranged for an independent psychiatrist, Dr. James O'Brien, to examine Plaintiff in order to determine whether he was psychologically disabled within the meaning of the Plan Documents. After examining Plaintiff, Dr. O'Brien reported that Plaintiff was "consciously exaggerating his psychological and orthopedic difficulties." (A.R. DEL1207.) Dr. O'Brien further opined that "Mr. Regula can return to work immediately and that there is no type of work within his job description that he would not be able to do." (A.R. DEL1208.)

In a letter dated July 25, 1995, the Plan notified Plaintiff that it determined that he was able to work and that he therefore was no longer entitled to disability benefits. (A.R. DEL1214-15.) Accordingly, the Plan discontinued such benefits, effective July 25, 1995.

Through his attorney, Plaintiff appealed the denial of benefits on September 28, 1995, to the Administrative Subcommittee. The Subcommittee concluded that the denial of continued long term disability benefits to Plaintiff was proper. On December 6, 1995, Plaintiff appealed the Subcommittee's determination to the Plan's Administrative Committee. In a letter dated February 13, 1996, the Plan informed Plaintiff that it found that he "was not totally disabled within the meaning of the Plan." (A.R. DEL1436-38.)

Plaintiff filed the instant action on October 17, 1996, for declaratory relief and disability benefits under the Plan. Plaintiff now moves for summary judgment on both of those claims.

## III.

## DISCUSSION

### A. Standard for Issuance of Summary Judgment

Summary judgment is appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56. The moving party bears the initial responsibility of identifying the absence of a genuine material issue of fact. *Celotex v. Catrett*, 477 U.S. 317, 323 (1986).

In opposing the motion for summary judgment, the non-moving party is required by Rule 56(e) to go beyond the pleadings and designate specific facts showing that there is a genuine issue for trial. *Celotex*, 477 U.S. at 324. Non-moving parties can meet this burden by use of affidavits, depositions, answers to interrogatories, or admissions on file. *Id.*, However, conclusory allegations unsupported by factual data are insufficient to create a triable issue of fact so as to preclude issuance of summary judgment. *Hansen v. United States*, 7 F.3d 137, 138 (9th Cir. 1993).

### B. Applicable Standard of Review

It is well settled that courts must apply an "abuse of discretion" standard in reviewing a denial of benefits where the language of an ERISA-governed plan gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan. *Snow v. Standard Ins, Co.*, 87 F.3d 327, 330 (9th Cir. 1996). In this case, section 12.02 of the Plan Documents provides that "[t]he Administrative Committee shall have the broadest discretionary authority permitted under law in the exercise of all its functions including,

but not limited to, deciding questions of eligibility, interpretation, and the right to benefits hereunder . . ." (Compl., Ex. 1 at 51.) Because the Plan Documents clearly give the Administrative Committee broad discretionary authority to determine eligibility under the Plan, and to interpret the terms of the Plan Documents, the Court must review the Administrative Committee's decision to revoke Plaintiff's long term disability benefits for an abuse of discretion.[5]

A plan administrator's interpretation of the plan and its decisions regarding benefits claims are given broad deference when reviewed by the court for an abuse of discretion. An administrator will have abused its discretion if it makes a decision "without any explanation, or in a way that conflicts with the plain language of the plan, or that is based on clearly erroneous findings of fact." *Snow*, 87 F.3d at 331 (*quoting Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323-24 (9th Cir. 1995)). "Review under the 'clearly erroneous' standard is significantly deferential, requiring a 'definite and firm conviction that a mistake has been committed.' " *Snow*, 87 F. 3d at 331 (*quoting Concrete Pipe & Prods., Inc. v. Construction Laborers Pension Trust*, 508 U.S. 602, 623 (1993)). Under that standard, the court must determine whether the plan administrator's interpretation of the plan is a reasonable one, not whether it is the correct one or whether it is the interpretation that the court would

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[5] Plaintiff argues that under *Jordal v. Simmons*, 926 F.2d 223, 225-26 (2d Cir. 1991), the Court must review the Administrative Committee's decision *de novo* because the Administrative Committee denied his long term disability benefits after reevaluating his status, rather than initially. There is no case law supporting Plaintiff's position, and Plaintiff's reliance on *Jordal* is entirely misplaced. Unlike the instant case, in *Jordal*, the court found that the plan trustees were not given discretion to construe the applicable plan.

have made on its own. *See Snow*, 87 F.3d at 332 ("[The 'clearly erroneous'] standard certainly does not permit the overturning of a decision where there is *substantial evidence* to support the decision, that is, where there is 'relevant evidence [that] reasonable minds might accept as adequate to support a conclusion even if it is possible to draw two inconsistent conclusions from the evidence.") *(quoting Maynard v. City of San Jose*, 37 F.3d 1396, 1404 (9th Cir. 1994) (emphasis added)). In making that determination, the court is limited to the facts known to the administrator at the time the benefits claim decision was made. *Taft v. Equitable Life Assur. Soc.*, 9 F.3d 1469, 1471 (9th Cir. 1993).

### C. Plaintiff's Motion for Summary Judgment

Plaintiff seeks judgment reversing the decision of the Plan and granting him disability benefits. Plaintiff makes three arguments in support of his Motion for Summary Judgment. First, Plaintiff argues that the Administrative Committee erred because it refused to apply the "treating physician rule," which requires the Administrative Committee to give greater weight to the opinions of Plaintiff's treating physicians than to the opinions of the independent medical examiners concerning his disability. Second, Plaintiff argues that the Administrative Committee's decision that he was no longer eligible for long term disability benefits was an abuse of discretion because it was not supported by substantial evidence. Third, Plaintiff argues that the Plan abused its discretion by concluding that Plaintiff could perform some type of work since that determination was not supported by vocational evidence.

Finally, Plaintiff argues that, in the alternative to granting summary judgment in his favor, the Court should, at a minimum, remand this matter for further

proceedings under the Plan because the Administrative Committee failed to provide him with the opportunity for a full and fair review.

1. *The Treating Physician Rule Does Not Apply In ERISA Actions*

Plaintiff argues that in determining whether he was permanently disabled under the Plan, the Administrative Committee should have applied the "treating physician rule." Under the "treating physician rule," a treating physician's opinion may be disregarded only where there are specific, legitimate reasons for doing so that are based on substantial evidence in the record. *Murray v. Heckler*, 722 F.2d 499, 501-2 (9th Cir. 1983). Although the "treating physician rule" is regularly applied in social security cases, and has also been applied in workers' compensation and Federal Tort Claims Act cases, the law is unsettled as to whether the rule applies in cases governed by ERISA. Indeed, the Ninth Circuit has never addressed the propriety of applying the treating physician rule in ERISA cases.

A requirement that a plan administrator must apply the "treating physician rule" is fundamentally inconsistent with the wide discretion granted to plan administrators in deciding claims for benefits under ERISA-governed welfare benefit plans. As discussed above, under ERISA, it the responsibility of a plan administrator to evaluate the evidence before him and to make an eligibility determination. The Court reviews that determination for an abuse of discretion, i.e., to determine whether it was made "without any explanation, or in a way that conflicts with the plain language of the plan, or that is based on clearly erroneous findings of fact." *Snow*, 87 F.3d at 331 (*quoting Atwood*, 45 F.3d at 1323-24. A requirement that the plan administrator must apply the "treating

physician rule" would require that the administrator weigh the facts in a particular fashion. This is inconsistent with the very deferential standard applied by the court in reviewing the administrator's decision.

Furthermore, as stated by the Fifth Circuit:

> We have considerable doubt about holding the rule applicable in ERISA cases. Under it, the treating physician would stand to profit greatly if the court were to find benefits should not be terminated. There is a clear and strong conflict of interest, and we are doubtful that a court should defer automatically to his or her testimony.

*Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992); *See also Jett v. Blue Cross and Blue Shield of Alabama*, 890 F.2d 1137, 1140 (11th Cir. 1989) ("The Social Security law that greater weight must be given to the opinion of the treating physician is not applicable to the decision of the claims administrator of an ERISA-governed employee health plan where the treating physician has an economic interest in the matter.")

Because the plan administrator has wide discretion in making eligibility determinations, that determination encompasses his decision as to whether the treating physicians' reports are entitled to greater weight than those of the non-treating physicians. Thus, if the administrator decides that, for some reason, the reports of the non-treating physicians are entitled to greater weight than the reports of the treating physicians, that determination may be overturned only if the court finds that the plan administrator abused his discretion in making such determination.

In this case, the Plan considered and rejected Plaintiff's argument that it should "give deference to the treating physician over that of other physicians":

> While the Committee agrees that in many cases the treating physician may know the most about an employee's condition, the Committee believes that there are many times when an independent or objective evaluation can be more valuable and insightful.

(A.R. DEL1438.)

Because it is within the discretion of the Administrative Committee to determine the weight to be given to the evidence presented with respect to Plaintiff's claim for benefits, the Court finds that the Administrative Committee did not abuse its discretion by refusing to apply the "treating physician rule" in making its determination as to Plaintiff's eligibility for long-term disability benefits.[6]

### 2. *The Administrative Committee's Decision Was Not, As A Matter Of Law, An Abuse Of Discretion*

Plaintiff argues that the Administrative Committee's decision that he was no longer eligible for long-term disability benefits was an abuse of discretion because it was

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[6] Courts deciding ERISA claims have routinely approved of plan administrators' use of non-treating and/or non-examining physicians' opinions in making eligibility determinations. *See, e.g., Sweatman v. Commercial Union Ins, Co.*, 39 F.3d 594, 601-02 (5th Cir. 1994) (finding no abuse of discretion where administrator relied on opinions of non-treating, independent doctors in determining the plaintiff's eligibility for benefits); *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir., 1994) (upholding plan administrator's denial of benefits where decision was based on a permissible choice between independent, non-examining medical consultants and plaintiff's physicians).

not supported by substantial evidence. It should be noted that "substantial evidence" does not mean a preponderance of the evidence. Rather, "substantial evidence" means " 'relevant evidence [that] reasonable minds might accept as adequate to support a conclusion even if it is possible to draw two inconsistent conclusions from the evidence.' " *Snow*, 87 F.3d at 332 (*quoting Maynard*, 37 F.3d at 1404. After reviewing the administrative record in its entirety, the court simply cannot find that, as a matter of law, the Administrative Committee's determination was not based upon "substantial evidence," i.e., that it was an abuse of discretion. *Id.*

The administrative record is not, as Plaintiff claims, entirely supportive of his claim that he is totally and permanently disabled. (*See*, *e.g.*, A.R. DEL1087, DEL1088, DEL1089, DEL1162, DEL1169.)[7] Furthermore, the independent medical examiners' opinions support the Administrative Committee's determination as to Plaintiff's orthopedic and psychological disabilities. (A.R. DEL1180-87, DEL1196-213.) Those opinions were rendered after reviewing Plaintiff's medical file and examining Plaintiff himself. They therefore cannot be said to be "clearly erroneous findings." Finally, because Plaintiff's treating physician Dr. Smith's reports are somewhat inconsistent (*see* A.R. DEL1169, DEL1171-73),

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[7] The Court rejects Plaintiff's argument that, as a matter of law, the Plan failed to demonstrate that Plaintiff did not "remain disabled" as required by the Plan. Plaintiff specifically claims that the Plan must demonstrate that Plaintiff's condition "improved" since the time that the Plan determined that he was disabled. Even assuming that the Plan must make such a showing, the independent medical examiners' opinions, which cannot be said as a matter of law to be "clearly erroneous findings," supported the Administrative Committee's determination. Thus, the Court cannot find, as a matter of law, that the Administrative Committee's determination was an abuse of discretion.

and because the independent examiners' detailed reports were prepared after reviewing Plaintiff's medical file and conducting examinations of Plaintiff himself, the Court cannot find that, as a matter of law, the Administrative Committee's decision to rely upon the independent examiners' opinions was an abuse of discretion.

3. *The Plan Was Not Required To Obtain Vocational Evidence To Make Its Determination As To Plaintiff's Qualification For Long-Term Benefits*

Plaintiff argues that the Plan abused its discretion by concluding that he could perform "some type of work" because that conclusion was not supported by vocational evidence. However, the Ninth Circuit has specifically rejected the notion that vocational evidence is necessary in all situations:

> In accord with the Fifth Circuit and the District of Columbia Circuit, we hold that consideration of vocational evidence is unnecessary where the evidence in the administrative record supports the conclusion that the claimant does not have an impairment which would prevent him from performing some identifiable job. The plan administrator is not required in every case where the 'any occupation' standard is applicable to collect vocational evidence in order to prove there are available occupations for the claimant.

*McKenzie v. General Telephone Co. of Cal.*, 41 F.3d 1310, 1317 (9th Cir. 1994), *cert. denied*, 514 U.S. 1066 (1995).

In this case, the Administrative Committee was not necessarily required to obtain vocational evidence to

support its determination that Plaintiff is not disabled because, as discussed above, the administrative record does not fail to support the Administrative Committee's determination as a matter of law. Furthermore, Plaintiff's argument that the Administrative Committee must identify a particular job which Plaintiff can perform is unsupported by case law. The Ninth Circuit has stated that an administrative committee must demonstrate that the participant can perform "some identifiable job," not "an identified job." *Id.* In this case, as noted above, the Plan relied upon the reports of Dr. Kumar, which details the restrictions on Plaintiff's ability to work (A.R. DEL1186), and Dr. O'Brien who opined that "there is no type of work within [Plaintiff's] job description that he would not be able to do." (A.R. DEL1208.) It clearly cannot be said that, as a matter of law, this is insufficient to support the Administrative Committee's determination that Plaintiff could perform "some type of work." *See McKenzie*, 41 F.3d at 1317-18.

The Court simply cannot find that the Administrative Committee's failure to obtain vocational evidence was an abuse of discretion as a matter of law.

4. *Plaintiff Was Not Denied A Full And Fair Review of His Claim For Benefits*

Plaintiff argues that, in making the final determination as to Plaintiff's eligibility for long-term disability benefits, the Plan failed to provide him with an opportunity for a full and fair review.

> An ERISA plan "shall provide to every claimant who is denied a claim for benefits written notice setting forth in a manner calculated to be understood by the claimant: (1) The specific reason or reasons for the denial; (2) Specific reference to per-

> tinent plan provisions on which the denial is based; (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review."

*Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997) (quoting 29 C.F.R. § 2560.503-1(f)). "In simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries." *Id.*

In this case, Plaintiff was not denied the opportunity for a full and fair review of the denial of his claim for benefits. The initial denial of benefits to Plaintiff (A.R. DEL1346-47), the denial of Plaintiff's appeal to the Administrative Subcommittee (DEL1357-58, DEL1359-60), and the denial of Plaintiff's appeal to the Administrative Committee (A.R. DEL1436-38) specify in detail the documents reviewed and the basis for the decision. Furthermore, the Plan clearly advised Plaintiff of the steps to be taken in the event that Plaintiff wished to submit his claim for review (*see* A.R. DEL1346-47, DEL1359-60), and any additional information that would assist Plaintiff to perfect his claim. (*See* A.R. DEL1346-47, DEL1422-23.) Thus, the Court finds that Plaintiff was not denied a full and fair review of his claim, and the Court shall not remand this matter for further proceedings under the Plan.

## IV.

## CONCLUSION

Plaintiff's Motion for Summary Judgment is **DENIED.** The Court finds that the "treating physician rule" does not apply to ERISA cases and that the Administrative Committee's decision that Plaintiff was no longer eligible for long term disability benefits was not, as a matter of law, an abuse of discretion. Finally, Because Plaintiff was not denied the opportunity for a full and fair review, the Court shall not remand this matter for further proceedings under the Plan.

In opposition to Plaintiff's Motion for Summary Judgment, the Plan argues that, not only should the Court deny Plaintiff's Motion, but the Court should also grant summary judgment in favor of the Plan, *sua sponte*. The Court, however, will not address the merits the Plan's argument that it is entitled to judgment in its favor absent a properly noticed motion.

Thus, the Court hereby sets the pre-trial conference in this matter for April 20, 1998, at 11:00 a.m., and a two-day court trial for May 12, 1998, at 9:00 a.m.

**IT IS SO ORDERED.**

/s/ RONALD S.W. LEW
RONALD S.W. LEW
United States District Judge

DATED: February 17, 1997

No. CV-96-7304-RSWL; *Regula v. Delta Family-Care Disability & Survivorship Plan*; Plaintiff's Motion for Summary Judgment (Regulasj.ord.o)

I HEREBY CERTIFY THAT THIS DOCUMENT WAS SERVED BY FIRST CLASS MAIL, POSTAGE PREPAID, TO ALL COUNSEL (OR PARTIES) AT THEIR RESPECTIVE MOST RECENT ADDRESSES OF RECORD IN THIS ACTION ON THIS DATE.

DATED: 2/18/98
HELENA G. [ILLEGIBLE]
DEPUTY CLERK

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

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Case No.: CV 96-7304 RSWL(VAPx)
Filed March 25, 1998

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FRANK REGULA,

*Plaintiff,*

—VS.—

DELTA FAMILY-CARE DISABILITY AND SURVIVORSHIP PLAN,

*Defendant.*

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# STIPULATION FOR THE ENTRY OF JUDGMENT; AND ORDER

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TO THE HONORABLE RONALD S. W. LEW, JUDGE OF THE DISTRICT COURT:

Whereas plaintiff Frank Regula filed a motion for summary judgment in the above-captioned matter on August 11, 1997, which defendant Delta Family-Care Disability and Survivorship Plan opposed;

Whereas the court has issued an order denying plaintiff's motion for summary judgment;

Whereas the issues at trial are identical to those issues set forth in plaintiff's motion for summary judgment and defendant's opposition thereto;

Whereas of the facts before the court at trial are limited to the record before the plan administrator of defendant, consisting of the record before the court on the motion for summary judgment; and

Whereas the parties wish to preserve scarce resources;

THE PARTIES HEREBY STIPULATE AND AGREE AS FOLLOWS:

If the "treating physician rule" does not apply to ERISA cases, and if the Administrative Committee's decision that plaintiff was no longer entitled to long term disability benefits was not, as a matter of law, an abuse of discretion, and if plaintiff was not denied an opportunity for full and fair review, then plaintiff cannot prevail at trial and defendant is entitled to judgment.

Plaintiff Frank Regula has preserved his rights to appeal on his contentions raised in his motion for summary judgment. The court has necessarily rejected as a matter of law each of the points raised.

Based upon the decision of the District Court, defendant is entitled to judgment.

IT IS SO STIPULATED.

DATE: March 13, 1998

Respectfully submitted,

LAW OFFICES OF LAWRENCE D. ROHLFING

By: LAWRENCE D. ROHLFING
Lawrence D. Rohlfing
Attorney for plaintiff FRANK REGULA

DATE: March 24, 1998

MUNGER, TOLLES & OLSON, LLP

By: [ILLEGIBLE]
D. Barclay Edmundson
Attorneys for defendant DELTA FAMILY-CARE AND SURVIVORSHIP PLAN

**ORDER**

IT IS SO ORDERED.

DATE: March 25, 1998

RONALD S.W. LEW
THE HONORABLE RONALD S.W. LEW
JUDGE OF THE DISTRICT COURT

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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No. 98-55853
D.C. No. CV-96-07304-RSWL
Filed March 15, 2002

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FRANK REGULA,

*Plaintiff-Appellant*,

—v.—

DELTA FAMILY-CARE DISABILITY
SURVIVORSHIP PLAN,

*Defendant-Appellee*.

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Before: B. FLETCHER, D.W. NELSON, and BRUNETTI,
*Circuit Judges*

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ORDER

A majority of the panel has voted to deny the petition for rehearing. Judges B. Fletcher and D.W. Nelson recommended denying the petition for rehearing en banc and Judge Brunetti recommended in favor of rehearing en banc.

The full court was advised of the petition for rehearing en banc. An active judge requested a vote on whether

to rehear the matter en banc. The matter failed to receive a majority of the votes of the non-recused active judges in favor of en banc consideration. Fed. R. App. P. 35.

The petition for rehearing is denied and the petition for rehearing en banc is rejected.

**29 U.S.C. § 1132. Civil Enforcement**

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

* * *

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

**29 C.F.R. § 2560.503-1 Claims procedure.**

(a) Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

(b) Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if—

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

(2) A description of all claims procedures (including, in the case of a group health plan within the meaning of paragraph (m)(6) of this section, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures) and the applicable time

frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102-3;

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits. Also, the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant (e.g., in the case of a group health plan, the claimant is unconscious and in need of immediate care at the time medical treatment is required) would constitute a practice that unduly inhibits the initiation and processing of a claim;

(4) The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, within the meaning of paragraph (m)(1) of this section, a health care professional, within the meaning of paragraph (m)(7) of this section, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant; and

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify

that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

(6) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees)—

(i) Such plan will be deemed to comply with the provisions of paragraphs (c) through (j) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference—

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which adverse benefit determinations are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (h), (i), and (j) of this section (but will not be deemed to comply with paragraphs (c) through (g) of this section) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which adverse benefit determinations are subject (but not provisions concerning the filing and initial disposition of benefit claims).

(c) Group health plans. The claims procedures of a group health plan will be deemed to be reasonable only if, in addition to complying with the requirements of paragraph (b) of this section—

(1)(i) The claims procedures provide that, in the case of a failure by a claimant or an authorized representative of a claimant to follow the plan's procedures for filing a pre-service claim, within the meaning of paragraph (m)(2) of this section, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

(ii) Paragraph (c)(1)(i) of this section shall apply only in the case of a failure that—

(A) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(B) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

(2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act;

(3) To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those

permitted by paragraph (c)(2) of this section, the claims procedures provide that:

(i) The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

(ii) The plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

(iii) The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by paragraph (c)(2) of this section;

(iv) The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(v) No fees or costs are imposed on the claimant as part of the voluntary level of appeal.

(4) The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit

determinations, except to the extent that the plan or procedures provide that:

(i) The arbitration is conducted as one of the two appeals described in paragraph (c)(2) of this section and in accordance with the requirements applicable to such appeals; and

(ii) The claimant is not precluded from challenging the decision under section 502(a) of the Act or other applicable law.

(d) Plans providing disability benefits. The claims procedures of a plan that provides disability benefits will be deemed to be reasonable only if the claims procedures comply, with respect to claims for disability benefits, with the requirements of paragraphs (b), (c)(2), (c)(3), and (c)(4) of this section.

(e) Claim for benefits. For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. In the case of a group health plan, a claim for benefits includes any pre-service claims within the meaning of paragraph (m)(2) of this section and any post-service claims within the meaning of paragraph (m)(3) of this section.

(f) Timing of notification of benefit determination. (1) In general. Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. If the plan admin-

istrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination in accordance with paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the Plan administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(i) shall be made in accordance with paragraph (g) of this section. The plan administrator shall notify the claimant of the plan's ben-

efit determination as soon as possible, but in no case later than 48 hours after the earlier of—

(A) The plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information.

(ii) Concurrent care decisions. If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments—

(A) Any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph (g) of this section, and appeal shall

be governed by paragraph (i)(2)(i), (i)(2)(ii), or (i)(2)(iii), as appropriate.

(iii) Other claims. In the case of a claim not described in paragraphs (f)(2)(i) or (f)(2)(ii) of this section, the plan administrator shall notify the claimant of the plan's benefit determination in accordance with either paragraph (f)(2)(iii)(A) or (f)(2)(iii)(B) of this section, as appropriate.

(A) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(iii)(A) shall be made in accordance with paragraph (g) of this section.

(B) Post-service claims. In the case of a post-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable

period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(3) Disability claims. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the

circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(4) Calculating time periods. For purposes of paragraph (f) of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (f)(2)(iii) or (f)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(g) Manner and content of notification of benefit determination. (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant —

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this section is furnished to the claimant not later than 3 days after the oral notification.

(h) Appeal of adverse benefit determinations. (1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically

necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which—

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

(i) Timing of notification of benefit determination on review. (1) In general. (i) Except as provided in paragraphs (i)(1)(ii), (i)(2), and (i)(3) of this section, the plan administrator shall notify a claimant in accordance with paragraph (j) of this section of the plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(1)(i) of this section shall not apply, and, except as provided in paragraphs (i)(2) and (i)(3) of this section, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such

as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination on review in accordance with paragraphs (i)(2)(i) through (iii), as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.

(ii) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides

for one appeal of an adverse benefit determination, such notification shall be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination.

(iii) Post-service claims. (A) In the case of a post-service claim, except as provided in paragraph (i)(2)(iii)(B) of this section, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the plan of the claimant's request for review of the adverse determination.

(B) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(2)(iii)(A) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for

review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(3) Disability claims. (i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1) of this section, except that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.

(ii) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(3)(i) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for

review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(4) Calculating time periods. For purposes of paragraph (i) of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (i)(1), (i)(2)(iii)(B), or (i)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on

which the claimant responds to the request for additional information.

(5) Furnishing documents. In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate.

(j) Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant—

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits—

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(k) Preemption of State law. (1) Nothing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.

(2)(i) For purposes of paragraph (k)(1) of this section, a State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review

procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing.

(ii) The State law procedures described in paragraph (k)(2)(i) of this section are not part of the full and fair review required by section 503 of the Act. Claimants therefore need not exhaust such State law procedures prior to bringing suit under section 502(a) of the Act.

(l) Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(m) Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

(1)(i) A "claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations—

(A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(B) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the

claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(ii) Except as provided in paragraph (m)(1)(iii) of this section, whether a claim is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i)(A) of this section is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(iii) Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i) of this section shall be treated as a "claim involving urgent care" for purposes of this section.

(2) The term "pre-service claim" means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(3) The term "post-service claim" means any claim for a benefit under a group health plan that is not a pre-service claim within the meaning of paragraph (m)(2) of this section.

(4) The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or

make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(5) The term "notice" or "notification" means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual.

(6) The term "group health plan" means an employee welfare benefit plan within the meaning of section 3(1) of the Act to the extent that such plan provides "medical care" within the meaning of section 733(a) of the Act.

(7) The term "health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph

(b)(5) of this section in making the benefit determination; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(n) Apprenticeship plans. This section does not apply to employee benefit plans that solely provide apprenticeship training benefits.

(o) Applicability dates. This section shall apply to claims filed under a plan on or after January 1, 2002.

[65 FR 70265, Nov. 21, 2000]

**20 C.F.R. § 404.1527(d) Evaluating opinion evidence.**

(d) How we weigh medical opinions. Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (d)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) Examining relationship. Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) Treatment relationship. Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (d)(2)(i) and (d)(2)(ii) of this section, as well as the factors in paragraphs (d)(3) through (d)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

(i) Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(ii) Nature and extent of the treatment relationship. Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) Supportability. The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend

on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) Consistency. Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) Specialization. We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) Other factors. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(e) Medical source opinions on issues reserved to the Commissioner. Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(2) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) Opinions that you are disabled. We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled.

(2) Other opinions on issues reserved to the Commissioner. We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to this subpart, your residual functional capacity (see Secs. 404.1545 and 404.1546), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (e)(1) and (e)(2) of this section.

# SELECTED PROVISIONS OF THE DELTA FAMILY-CARE DISABILITY AND SURVIVORSHIP PLAN

## SECTION FOUR

## DISABILITY BENEFITS

4.01 *Eligibility for Disability*: An Employee shall be eligible for Short-Term Disability Benefits under Section 4.02 of the Plan only if such disability commences while the Employee is eligible under Sections 2.01 (a) or 2.02. An Eligible Employee shall be eligible for Long-Term Disability Benefits under 4.02 only if such disability commences while the Employee is eligible under Sections 2.01 (b) or 2.02; provided, however, an Employee shall not be eligible for Long Term Disability Benefits for any disability commencing after age 65. An Employee who is eligible for either Short-Term or Long-Term Disability Benefits under the Plan shall be eligible for such benefits only so long as he is under the care of a physician or surgeon for the injury or disease or pregnancy which is the disabling condition and meets the other requirements of the Plan.

* * *

4.03 *Long Term Disability*: If upon expiration of the Employee's Short Term Disability period, he continues to qualify for Short Term Disability, the Employee may apply for Long Term Disability. The Employee shall be eligible for Long Term Disability provided he is disabled at that time as a result of demonstrable injury or disease (including mental or nervous disorders) which will continuously and totally prevent him from engaging in any occupation whatsoever for compensation or profit, including part-time work. During the period an

Employee qualifies for Long Term Disability, he will be eligible to receive monthly income benefits in an amount determined under Section 7.02. The Employee shall be eligible for Long Term Disability benefits so long as he remains disabled in accordance with this subsection and Section 4.01.

* * *

4.05 *Determination of Disability*: Disability as herein defined in Sections 4.02 and 4.03 shall be determined by the Administrative Committee or its designees in their sole discretion. The Committee or its designees may request a medical examination of the Employee by a physician or physicians appointed on behalf of the Committee before determining disability and during the disability period to determine if the Employee remains disabled. Failure to cooperate with requests for medical examination made on behalf of the Committee shall be grounds for denying disability benefits hereunder.

## SECTION ELEVEN

## CONTRIBUTIONS AND BENEFIT FUND

11.01 *Employee Contributions*: No contributions shall be required from an Employee, except that an Employee on approved leave of absence, as described in Section 2.01(d)(vii), and Temporary Employees described in Section 2.01(d)(iv) must contribute to be eligible for or to continue coverage for Basic Life Benefits hereunder. The amount of contribution required shall be determined by the Administrative Committee from time to time on a uniform basis with respect to all persons similarly situated. Such contributions must be paid monthly in advance and will be used to provide benefits under the Plan.

11.02 *Contributions By The Employing Companies*: The Plan shall engage an Actuary to submit annually an actuarial valuation evidencing the actuarial position and actuarial costs of the Plan. Each such actuarial statement or actuarial valuation shall give regard to the Plan's short-term and long-term financial needs, including liquidity requirements, and shall be forwarded to the person or persons in the Employing Company designated by the Administrative Committee to review such statements and valuations and to recommend appropriate contributions to the Benefit Fund by the Employing Companies. The contributions of the Employing Companies shall be paid at reasonable periodic intervals taking into consideration the recommendations contained in the latest actuarial valuation.

11.03 *Benefit Fund*: The Company shall establish and maintain a Benefit Fund into which the contributions of each Employing Company under this Plan shall be paid and all benefits will be paid exclusively from the Benefit Fund. The Benefit Fund may comprise any combination of trust funds and insurance contracts. The Benefit Fund shall be allocated among Employing Companies under the direction of the Administrative Committee. Where an Employee transfers from one Employing Company to another he shall be treated to the extent practical and consistent with his accumulated credits as having always been with the new Employing Company for the purpose of allocated assets and liabilities.

11.04 *Exclusive Benefit Rule*: At no time shall any part of the corpus or income of the Benefit Fund be used for or diverted to any purpose other than for the exclusive benefit of the Participants and their Beneficiaries and defraying reasonable expenses of administering the Plan. No person, including the Employing Companies,

shall have any financial interest in or right to the Benefit Fund or part thereof, except as expressly provided for in the Plan and the Trust.

11.05 *Source of Benefit Payments*: Benefit payments shall be paid directly to the Participant or Beneficiary from the Benefit Fund including any insurance policies entered into by the Plan. Such payments shall be made upon the written order of the Administrative Committee or its delegate. Resources for benefit payments are limited to the Benefit Fund and any insurance policies owned by the Benefit Fund.

11.06 *Forfeitures and Investment Income*: Forfeitures and investment income shall be used to reduce Company contributions and shall not be used hereunder to increase the benefit of any person prior to termination of the Plan or complete discontinuance of contributions.

## SECTION TWELVE

## ADMINISTRATION

12.01 *Administrative Committee*: The operation and administration of the Plan (except the responsibility for investment and control of assets, which is given to the Benefit Funds Investment Committee pursuant to Section 12.07 of this Plan), the exclusive power to interpret it, and the responsibility for carrying out its provisions are vested in the Administrative Committee of at least three members, which Committee shall be the Administrator of the Plan, provided, however, that this responsibility shall not extend to the management and control of the assets of the Plan. The Board of Directors of the Company shall appoint the Administrative Committee members and their alternates and shall have the power of removal and substitution, and shall designate the Chairman of the Com-

mittee. Any Administrative Committee member may resign by notifying the Company and the Administrative Committee Secretary in writing. The Administrative Committee shall establish rules for administration of the Plan and transaction of its business. The Administrative Committee shall be the named fiduciary of the Plan for purposes of operation and administration of the Plan, and, in addition, any duty which is not expressly allocated to the Benefit Funds Investment Committee, or with respect to which an allocation is in doubt, shall be deemed to be allocated to the Administrative Committee.

12.02 *Powers and Duties of the Administrative Committee*: In addition to powers and duties otherwise stated in this Plan, the Administrative Committee shall have such duties and powers as may be necessary to discharge its responsibilities under the Plan, including, but not limited to, the following:

(a) To establish and enforce such rules, regulations, and procedures as it shall deem necessary or proper for the efficient operation and administration of the Plan;

(b) The discretionary authority to interpret and construe the Plan, and decide all questions of eligibility of any Eligible Family Member to participate in the Plan or to receive benefits under it, its interpretation and decisions to be final and conclusive.

(c) To determine the amount, manner, and time of payment of benefits which shall be payable to any Employee or Dependent, in accordance with the provisions of the Plan, and to determine the person or persons to whom such benefits shall be paid;

(d) To authorize the payment of benefits and reasonable expenses for administering the Plan;

(e) To prescribe procedures to be followed in filing applications for benefits;

(f) To prepare and distribute, in such manner as the Administrative Committee determines to be appropriate and consistent with applicable law, information explaining the Plan;

(g) To decide all questions concerning the Plan;

(h) To furnish the Board of Directors of the Company, upon request, and government agencies as required, such reports with respect to the administration of the Plan as are reasonable and appropriate, and

(i) To delegate its power and duties as set forth in Section 12.04.

The Administrative Committee shall have the broadest discretionary authority permitted under law in the exercise of all its functions including, but not limited to, deciding questions of eligibility, interpretation, and the right to benefits hereunder but shall act in an impartial and non-discriminatory manner with respect thereto.

12.03 *Administrative Committee Actions*: The decisions of the Administrative Committee as to interpretation and application of the Plan shall be final. A certification of acts and directives of the Committee by the Secretary of the Administrative Committee shall constitute complete proof to third parties dealing with the Administrative Committee of the authenticity of such acts and directives.

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February 13, 1996

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Re: Frank Regula

At its February 13 meeting, the Administrative Committee considered your client's appeal regarding the denial of long term disability benefits. To receive benefits, Section 4.03 of the Plan requires that "an employee shall be eligible for long-term disability provided he is disabled at that time as a result of demonstrable injury or disease (including mental or nervous disorders) which will continuously and totally prevent him from engaging in any occupation whatsoever for compensation or profit, including part-time work." In reviewing the claim, the Committee considered all of the information in your client's file, including all of your arguments in support of the claim.

The Committee noted the large amount of medical information in this file dating back for several years. Initially the Committee noted that there were several inconsistent reports regarding Mr. Regula's condition, particularly amongst the doctors who have examined him

for his workers' compensation benefits. While some of the medical reports indicated that Mr. Regula is totally disabled, other reports stated that he was only disabled from overhead lifting and other strenuous activity. (See the May 25, 1989 report of Dr. Michael Smith and the January 1991 report of Dr. Alban. Additionally, see the report of Dr. Wixen who disagreed with Dr. Bloch as to the extent of Mr. Regula's difficulties.) In light of the conflicting information, the Committee noted that the Plan had ordered two independent medical examinations. The medical IME, Dr. Kumar, after performing an examination and review of the pertinent medical records, stated that Mr. Regula is "definitely capable" of working. The psychiatric IME, Dr. O'Brien, provided a strong opinion that he believed Mr. Regula to be malingering and that there was no cognitive impairment. Dr. O'Brien also stated that he does not lightly or quickly suggest that an individual is malingering. The Committee also noted Dr. O'Brien's criticism of Dr. Smith's opinions, and Dr. O'Brien's statement that Mr. Regula's failure to consider prescription drug therapy is "ridiculous."

In support of the claim, the Committee reviewed all of the recent reports from Dr. Shapero, Dr. Smith and the chiropractor, Dean Cummings, in addition to all of the prior reports from Dr. Michael Smith, Dr. Bloch and the other physicians. The Committee noted that Dr. Shapero was treating Mr. Regula for gastrointestinal problems. The Committee did not find Dr. Shapero's statements persuasive since he is not qualified to, and pointed out that he would not, opine on Mr. Regula's orthopedic and psychological difficulties.

With regard to Dr. Smith, the Committee noted Dr. O'Brien's criticisms of her opinion, and also reviewed Dr. Smith's comments about Dr. O'Brien's opinion. The Committee noted that Dr. Smith was opining on Mr.

Regula's orthopedic difficulties when she is not an orthopedic medical doctor. With regard to Mr. Regula's psychiatric care, the Committee found it difficult to believe that Mr. Regula will not consider prescription medicine therapy and also found it difficult to believe that Dr. Smith would state that he is totally disabled and continue to treat him without the use of medication. As Dr. O'Brien pointed out, a large amount of time has elapsed since Mr. Regula first tried prescription medicine therapy. Since that time, many new medicines have been developed that may not have the same side effects. To the Committee, Mr. Regula's refusal to consider prescription drug treatment gives the impression that he does not want to improve or that he is not truly disabled.

The Committee also considered the opinion of Dr. Cummings, but the Committee also noted that except for Dr. Cummings report, there is no current orthopedic or other medical information in the file that addresses the hand injury or back and neck pain and difficulties, which were the original bases for Mr. Regula's disability claim. The last information of this type was dated approximately 1990 or 1991. The Committee noted that this had been pointed out to you prior to the meeting.

After reviewing all of this information, the Committee determined that Mr. Regula is not totally disabled within the meaning of the Plan. The Committee was persuaded by the reports of the IME physicians, the lack of current medical information regarding Mr. Regula's hand and back injury, and the fact that Mr. Regula claims to be totally disabled from a psychological standpoint, but yet he refuses to consider any medication to treat his illness.

Finally, the Committee considered your arguments about their reliance on the treating physician's opinions. First, we disagree that the current ERISA case law

requires the Plan to give deference to the treating physician over that of other physicians. While the Committee agrees that in many cases the treating physician may know the most about an employee's condition, the Committee believes that there are many times when an independent or objective evaluation can be more valuable and insightful. Second, even if your position was correct, there was ample evidence in the file to suggest that the opinions of the treating physicians should be discounted. Primarily, the strong evidence that Mr. Regula is malingering would permit the Committee to place more emphasis on the opinion of the IME over that of the treating psychologist. Additionally, the Committee felt that there was no current opinion from a medical doctor regarding Mr. Regula's hand and back. As described above, Dr. Shapero could not and would not speak on these issues. Due to this, the Committee relied on the current medical opinion from the IME, Dr. Kumar.

Sincerely,

/s/ MONTY HILL

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

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No. 01-15450
Non-Argument Calendar
D.C. Docket No. 00-00577-CV-CAM-1

---

VICKIE C. TURNER,

*Plaintiff-Appellant.*

—versus—

DELTA FAMILY-CARE DISABILITY
AND SURVIVORSHIP PLAN,

*Defendant-Appellee.*

---

Appeal from the United States District Court
for the Northern District of Georgia

---

**(April 9, 2002)**

Before TJOFLAT and BIRCH, Circuit Judges,
and SHAPIRO*, District Judge.

---

* Hon. Norma L. Shapiro, U.S. District Judge for the Eastern District of Pennsylvania, sitting by designation.

PER CURIAM:

Appellant Turner filed this action in state court to recover long term disability benefits from Appellee, Delta Family-Care Disability and Survivorship Plan (the "Plan"). The Plan, a non-contributory ERISA plan sponsored, funded and administered by Turner's former employer, Delta Air Lines, removed the action to federal court. On cross-motions for summary judgment filed in the District Court, the Plan's motion for summary judgment was granted. Turner timely appealed.

*STATEMENT OF FACTS*

The Plan is an ERISA non-contributory employee welfare benefit plan as defined in 29 U.S.C. § 1002(1). It provides short and long term disability benefits, as well as other benefits, to non-pilot Delta employees. The Administrative Committee of Delta Air Lines, Inc. is the Plan Administrator and the Named Fiduciary (as those terms are defined in ERISA).

Section 4.03 of the Plan sets forth the eligibility criteria for Long Term Disability Benefits and states, in relevant part:

> The Employee shall be eligible for Long Term Disability provided [s]he is disabled at that time as a result of demonstrable injury or disease (including mental or nervous disorders) which will continuously and totally prevent [her] from engaging in any occupation whatsoever for compensation or profit, including part-time work, but not including work performed in connection with a rehabilitation program approved by the Administrative Committee.

Section 12.01 of the Plan provides that the Administrative Committee, the Named Fiduciary of the Plan for purposes of operation and administration, has the exclusive power to interpret the Plan:

> The operation and administration of the Plan . . . the exclusive power to interpret it, and the responsibility for carrying out its provisions are vested in the Administrative Committee of at least three members, which Committee shall be the Administrator of the Plan. . . . The Administrative Committee shall establish rules for administration of the Plan and transaction of its business. The Administrative Committee shall be the named fiduciary of the Plan for purposes of operation and administration of the Plan. . . .

The powers and duties of the Administrative Committee are further defined in Section 12.02:

> In addition to powers and duties otherwise stated in this Plan, the Administrative Committee shall have such duties and powers as may be necessary to discharge its responsibilities under the Plan, including, but not limited to, the following:
>
> > (a) To establish and enforce such rules, regulations and procedures as it shall deem necessary and proper for the efficient operation and administration of the Plan;
> >
> > (b) The discretionary authority to interpret the Plan, and decide all questions of eligibility of any Eligible Family Member to participate in the Plan or to receive benefits under it, its interpretation and decisions to be final and conclusive;

> (c) To determine the amount, manner, and time of payment of benefits which shall be payable to any Employee or Dependent, in accordance with the provisions of the Plan, and to determine the person or persons to whom such benefits shall be paid;
>
> * * *
>
> (g) To decide all questions concerning the Plan;
>
> * * *
>
> (i) To delegate all its power and duties as set forth in Section 11.04.
>
> **The Administrative Committee shall have the broadest discretionary authority permitted under law in the exercise of all of its functions including, but not limited to, deciding questions of eligibility, interpretation, and the right to benefits hereunder but shall act in an impartial and nondiscriminatory manner with respect thereto.** (emphasis added.)

According to Section 12.03, the Administrative Committee's decisions "as to interpretation and application of the Plan shall be final."

While working as a flight attendant in August, 1996, Turner was injured and filed a claim for short term disability benefits, as well as a claim for workers' compensation. Short term disability benefits were payable as long as plaintiff could not return to her previous employment. Ms. Turner received short term disability benefits under the Plan from August 14, 1996 until February 11, 1997. Ms. Turner received workers' compensation benefits at the same time.

On February 8, 1997, Ms. Turner filed an application for long term disability benefits. Long term disability benefits were payable under the Plan so long as Ms. Turner was unable to engage in any occupation for compensation or profit, including part-time work. Ms. Turner's application for long term disability benefits was approved on April 3, 1997, effective February 12, 1997. Ms. Turner continued to receive long term disability benefits for two years (28 months) until June 7, 1999, when her benefits were stopped. The total period Ms. Turner received short and long term disability benefits was 34 months.

Turner appealed the termination of her long term disability benefits in June, 1999. Delta sent a clerical job description to one of Turner's treating physicians who responded that she could do clerical work with certain restrictions: changing positions as needed; no repetitive lifting, twisting or bending; and lifting limited to 10 pounds. This evaluation followed the doctor's earlier and subsequent recommendation of an intradiscal procedure to allow Turner to return to employment.

Turner's administrative appeal was denied as of June 7, 1999, "Based on the convincing opinions of her own physician, Dr. Chambers, and of the IME physician, Dr. Dopson, that you were able to perform some type of work as of your denial date and the lack of evidence to the contrary, the committee was not persuaded that you were eligible for additional long-term disability benefits."

## *STANDARD OF REVIEW*

A District Court grant of summary judgment is subject to *de novo* review. The Court of Appeals must determine whether, based on the evidence of record, it agrees with

the District Court that the Plan had some reasonable basis for its decision to discontinue claimant's long-term disability benefits so that the Plan's decision was not arbitrary or capricious. *Canadyne-Georgia Corp. v. Continental Ins. Co.*, 999 F.2d 1547, 1554 (11th Cir. 1993); *Paramore v. Delta Air Lines, Inc.*, 129 F.3d 1446, 1449-1452 (1997).

Ms. Turner contends the Plan's decision is subject to a modified arbitrary or capricious standard of review because Delta is making decisions over funds contributed by Delta and, as Plan funds are disbursed, Delta is obligated to replenish them. Even though the monies are paid from a trust funded by Delta through irrevocable periodic contributions, the Plan has finite resources to pay benefits and decisions on disbursements are made by a committee made up of Delta employees. Delta maintains control over benefits because its employees are on the Administrative Committee making decisions on benefits.

This court decided in *Paramore v. Delta Air Lines*, 129 F.3d 1446 (11th Cir. 1997), that the arbitrary or capricious standard of review applies to this Plan's decisions because of the broad discretion delegated to the Plan's Administrator in the Plan document. This court has also previously decided, in *Buckley v. Metropolitan Life Ins. Co.*, 115 F.3d 936 (11th Cir. 1997) (per curiam) that the funding structure utilized by this Plan eradicates any alleged conflict of interest so that the arbitrary or capricious standard of review applies.

In the more recent decision of *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1138 (9th Cir. 2001), the members of the Administrative Committee were appointed by the Delta Board of Directors; although the Benefit Fund was organized as a trust, it was funded exclusively by Delta companies based on

actuarial data and Delta effectively acted as both administrator and funding source for the Plan. The 9th Circuit Court of Appeals held in *Regula*, "[u]nder such circumstances, Plan benefits decisions are subject to a less deferential standard of review." But Turner's argument that this less deferential standard should apply here is unavailing because of the decisions of this Court to the contrary.

Turner also argues that the District Court failed to give deference to the opinions of her treating doctors. She again relies on *Regula*. The 9th Circuit Court of Appeals held not only that Plan benefit decisions are subject to a less deferential standard of review but also that due deference should be given to opinions of the treating physician who has a greater opportunity to know and observe the patient as an individual.

The *Regula* decision is contrary to the law of this Circuit and cannot govern this appeal. But even if it did, it would not benefit Turner as her treating physician on at least one occasion stated Turner was capable of performing the job description of a clerk, with minor restrictions. The Plan was entitled to rely on that opinion in July, 1999, even if in June, 1999, her doctor had been of the opinion she could not return to her previous occupation of flight attendant. The Plan criterion for long-term disability was inability to work at any occupation.

The Plan was also entitled to rely on the opinion of the independent medical examiner to whom Turner was referred in light of the surveillance report it requested. On January 20, 1999, Turner was observed by investigators for the Plan. Turner was walking in a fluid manner without visible restrictions or medical devices at a bank prior to a doctor's appointment. Turner was then observed walking from the doctor's office with a sig-

nificant limp and using a cane. Upon arrival at her home, Turner was observed leaning without assistance into the back seat of her car to remove her cane, and entering her residence "without limping as significantly as she did at the medical office, and she did not use her cane."

On February 3, 1999, Turner was again observed by investigators for the Plan. The investigator's report states Turner was observed driving alone to a nearby mall. She was inside the mall for approximately two hours, during which time she was observed walking, shopping, and descending stairs without the use of a cane. The investigator further observed that "[a]t times, she walked with an emphatic limp, and at other times her stride appeared fluid."

All medical reports and other evidence was considered; all procedures required by the Plan were followed. Whether or not Turner could return to regular duty as a flight attendant, the determination that she was not totally disabled from performing any work in June, 1999, was far from arbitrary and capricious. It is irrelevant that the court or anyone else might reach a different conclusion. Upon consideration of the briefs and record, there was no reversible error. The decision of the District Court is AFFIRMED.

Supreme Court, U.S.
FILED
JUL 18 2002
CLERK

No. 01-1840

In The

# Supreme Court of the United States

DELTA FAMILY-CARE DISABILITY
AND SURVIVORSHIP PLAN,

*Petitioner,*

v.

FRANK REGULA,

*Respondent.*

**On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit**

## RESPONDENT'S BRIEF IN OPPOSITION

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# I

## STATEMENT OF THE CASE

This is an ERISA disability case. Prior to June 9, 1987, plaintiff Frank Regula was a participant in the Delta Family-Care Disability and Survivorship Plan (hereinafter referred to as "Delta Plan"). Thereafter, he became a beneficiary. On or about June 9, 1987, Frank Regula suffered severe injury, became disabled from his usual and customary occupation, and no longer became able to work in any occupation for pay or profit. Petitioner, Delta Plan, allowed the claim for long-term disability benefits, effective October 31, 1987. Record 12 at Administrative Record (A.R.) 1031.[1]

Petitioner certified and accepted Regula's disability, based on information from his treating physicians, and determined him eligible for continuation of disability benefits thirteen times between 1987 and 1995. A.R. 1037, 1041, 1042, 1085, 1086, 1106, 1109, 1123, 1144, 1148, 1155, 1163, and 1166. Under the terms of the plan, plaintiff became disabled on June 9, 1987, and remained so continuously thereafter. *Id.*

On July 25, 1995, Petitioner determined that Frank Regula would no longer receive benefits effective July 25, 1995. A.R. 1214. The Petitioner determined that Frank

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[1] References to the administrative records consisting of the claim file produced in this action are referred to as A.R. with the appropriate page designation and can be found at Record 12. Plaintiff separately filed the administrative record in this action at the district court. The parties have agreed that this previously submitted record constitutes the administrative record.

Regula could perform some type of unspecified work activity. *Id.* Petitioner never found any medical improvement in Regula's condition. Section 4.03 of the Delta Plan language states that "the Employee shall be eligible for Long Term disability benefits so long as he remains disabled in accordance with this subsection and Section 4.01." (*Petitioner's Appendix* at 100a-101a) (Hereinafter *Pet. App.*).

Frank Regula filed a complaint in the United Sates District Court Central District of California on October 17, 1996, to reinstate his benefit entitlement. Record 1. The District Court, the Honorable Ronald S.W. Lew, United States District Judge presiding, issued an order denying Regula's motion for summary judgment. Record 11 and 21. The court declined to enter judgment *sua sponte* for defendant. *Id.*

Based upon the content of the order of the district court, the parties filed a stipulation for the entry of judgment for defendant. Record 22. Regula preserved his right to appeal on the contentions set forth in his motion for summary judgment. *Id.* The court entered judgment approving the stipulation on March 25, 1998. Record 23.

On April 21, 1998, Frank Regula filed his notice of appeal from the judgment of the District Court. Record 24. The United States Court of Appeals for the Ninth Circuit reversed the decision of the district court. (*Pet. App.* at 1a-46a). The court of appeals held that the "treating physician rule" found in the body of common law surrounding the Social Security Act, and contained within the substantial evidence rule in every legal framework where the federal courts review the decisions of a professional fact finder (a non-jury), applies to disability determinations

under ERISA.[2] (*Pet. App.* 13a-24a). The court of appeals painstakingly set out the bases and rationale for application of the treating physician rule in the ERISA disability context. (*Pet. App.* 13a-24a).[3] The Ninth Circuit recognized the treating physician rule was well settled by the circuit courts of appeals long before the Social Security Administration subsequently codified it. (*Pet. App.* 19a, *citing Murray v. Heckler,* 722 F.2d 499, 501 (9th Cir. 1983)).

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[2] This Court and the Circuit Courts have uniformly utilized the treating physician rule in litigation brought before the federal judiciary. *See Olmstead v. L.C.*, 527 U.S. 581, 610 (1999) (recognizing, within the context of the Americans with Disability Act (ADA), that the opinion of a responsible treating physician ought to be given the greatest of deference); and *Viteck v. Finch*, 438 F.2d 1157, 1160 (4th Cir. 1971) (utilizing the rule in cases arising under the Social Security Act); and *National Mining Assn v. Dept. of Labor*, No. 01-5278 (D.C. Cir. June 14, 2002) (Loislaw.com, D.C. Circuit Court of Appeals Reports) (utilizing the treating physician rule in cases arising under a claim for benefits under the Black Lung Act); and *Harris v. Railroad Retirement Bd.*, 948 F.2d 123, 126 (2nd Cir. 1991) (utilizing the treating physician rule to cases arising under the Railroad Retirement Act); and *Hensley v. Washington Metropolitan Area Transit Authority*, 655 F.2d 264, 273 fn. 13 (D.C. Cir. 1981) (utilizing the treating physician rule in the federal workers compensation setting); and *Curtis v. Shivers*, 674 F.Supp. 1237, 1240 (E.D. La. 1987) (utilizing the treating physician rule in cases arising under the Federal Tort Claims Act). *Cf. White v. Principi*, 243 F.3d 1378, 1380-1381 (Fed. Cir. 2001) (declining to utilize the treating physician rule within veterans' benefits cases, where Congress and the Veterans Administration specifically prescribed a statutory and regulatory framework for the consideration of evidence and where the treating physician would be employed by the fact-finding agency thereby putting the claimant at a disadvantage).

[3] The Ninth Circuit explained that the deference, as found by the federal courts, given to the treating opinion under the rule is not absolute and subject to rejection based on the articulation of sufficient reasons supported by substantial evidence within the record. *(See Pet. App.* at 16a-17a).

In applying the treating physician rule, the court of appeals recognized that in enacting ERISA, Congress created an elaborate framework of laws and regulations governing covered benefit plans in order to protect the rights of participants and their beneficiaries. (*Pet. App.* 22a *citing* 29 U.S.C. § 1001(b) (2000)); *see also Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (ERISA was enacted to promote the interests of employees and their beneficiaries and to protect contractually defined benefits).

The court of appeals further noted that this Court's ruling in *Firestone v. Bruch, supra*, intended to reconcile the joint objectives of the statute while simultaneously interpreting the provisions of ERISA in order to maintain their consistency with other settled principles of law. (*Pet. App.* 20a *citing Firestone v. Bruch*, 489 U.S. at 112). Mindful of the Supreme Court's compromise in *Firestone*, in interpreting the provisions and joint objectives of ERISA, the court of appeals confronted its similar problem in the present case and resolved the issue in accord with the Supreme Court's analysis in *Firestone*. (*Pet. App.* 17a-24a).

The Ninth Circuit further found that frank violation of the treating physician rule reflects a sufficient pervasive conflict of interest as to permit the court to deprive the defendant of a grant of discretion found in the plan documents as a matter of a remedy, remanding to the district court for further proceedings on that point. (*Pet. App.* 24a-31a). The court of appeals found an unsettling pattern of inconsistency and insufficiency in the plan administrator's reasons for terminating Frank Regula's benefits. (*Pet. App.* 28a-31a). The court of appeals held that deviation from the treating physician rule constitutes

material, probative evidence of a conflict. (*Pet. App.* 30a). Therefore, the court of appeals remanded to the district court to resolve Delta Plan's apparent conflict of interest and to apply the treating physician rule. (*Pet. App.* 31a).

## II

## SUMMARY OF THE ARGUMENT AND REASONS FOR DENYING THE WRIT

Petitioner presents two questions. The first is whether the "treating physician rule" found in the body of law surrounding Social Security cases decided by the circuit courts, and contained within the substantial evidence rule in every legal framework where the federal courts review the decisions of a professional fact finder (a non-jury), applies to disability determinations under ERISA. (*Petition for Writ of Certiorari* at *i*) (Hereinafter *Pet.*). Petitioner argues that the Ninth Circuit's opinion conflicts with the other circuit courts of appeals, conflicts with the deference accorded to benefit plan administrators under *Firestone v. Bruch, supra*, and disrupts the primary goal of ERISA, which Petitioner contends is the uniform administration of benefit plans. (*Pet.* at i and 12-14).

As read by the Petitioner, the Ninth Circuit's holding conflicts with the Fourth, Fifth, Sixth, Eighth, and Eleventh Circuit Courts of Appeals. (*Pet.* at 12-14). Petitioner attempts to conflate a conflict where none exists. The Ninth Circuit's opinion is consistent with decisions from the other circuit courts of appeals regarding the treating physician rule's applicability to ERISA. Even giving Petitioner's argument the liberalist of readings, as the Ninth Circuit noted, any apparition that is perceived as conflict amongst the circuit courts of appeals, is readably

distinguished as superficial on the unique facts addressed in each cited case.

The Ninth Circuit's decision stands congruent with this Court's decision in *Firestone v. Bruch, supra,* and this Court's most recent interpretation of *Firestone*. *See Rush Prudential HMO, Inc. v. Moran*, No. 00-1021 (U.S. 2002), 2002 DJDAR 6898, 6905 and 6905 fn. 15 (June 21, 2002). The Ninth Circuit scrupulously applied the same analysis, as this Court did in *Firestone*, in deciding this matter, recognizing that Congress empowered the courts to develop, in the light of reason and experience, a body of federal common law governing employee benefit plans. *See Menhorn v. Firestone Tire Rubber Co.*, 738 F.2d 1496, 1499 (9th Cir. 1984); *see also Rush Prudential HMO, Inc. v. Moran*, 2002 DJDAR at 6904 *citing Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987). Contrary to Petitioner's claim, the adoption of the treating physician rule provides for commonsense uniformity in the treatment of medical opinions and is consistent with the true primary goal of ERISA, which is to protect employee benefits.

The second issue asks how much discretion the plan's final decision should receive where the plan fiduciary operates under a conflict of interest, i.e., it is both responsible for the funding and administration of the plan. (*Pet.* at i and 23-26). Petitioner argues that the Ninth Circuit held that a *per se* conflict exists, even if the plan irrevocably sets aside funds. (*Pet.* at 15). Petitioner misrepresents the Ninth Circuit holding on conflict of interest as *per se*. It does not. As the Ninth Circuit recognized, a plan that establishes a trust, whether irrevocable or revocable, does not create a true trust where the employer both funds and administers the plan. (*Pet. App.* at 26a). Therefore, the Ninth Circuit's holding that Petitioner operates under a

conflict of interest based on its dual role, is consistent with this Court's pronouncement that a plausibly raised conflict suffices to examine the deference afforded in reviewing a plan's decision. *Rush Prudential HMO, Inc. v. Moran*, 2002 DJDAR at 6905 fn. 15.

## III

## ARGUMENT

### A

### NO CONFLICT EXISTS AMONG THE CIRCUIT COURTS OF APPEALS

Petitioner asserts that the Ninth Circuit's decision facially conflicts with the decisions in six other circuit courts of appeals, and thus provides a basis for the court to grant its petition for a writ of certiorari with respect to the application of the treating physician rule to ERISA disability claims. (*Pet.* at 20-22). Petitioner misstates the law. The court of appeals painstakingly set out the bases and rationale for application of the treating physician rule in the ERISA disability context. (*Pet. App.* at 13a-24a). The application of the treating physician rule in the Ninth Circuit is consistent with the decisions of the other circuit courts of appeals.

#### The Second Circuit Court Of Appeals

The Second Circuit Court of Appeals issued a decision on November 19, 2001, recognizing the treating physician rule to cases arising under ERISA. *See Conners v. Connecticut Gen. Life Ins. Co.*, 272 F.3d 127 (2nd Cir. 2001). In *Conners*, the court of appeals found error in the district court's failure to recognize that the treating physician was

in fact a treating physician, and that if the district court had properly so recognized, it would have no doubt accorded that opinion greater weight. *Conners*, 272 F.3d at 135-136. The weight accorded a treating physician under the treating physician rule represents nothing more than a starting point for commonsense analysis of whether the plan's final decision is legally sufficient.

The court of appeals did not adopt the treating physician rule for purposes of the *de novo* standard of review. *Id.*, at 136 fn. 4. The court of appeals in *Conners* explained that the treating physician rule is designed to "encourage the development of the administrative record so that the district court can determine whether the administrator's decision was supported by substantial evidence." *Id.* Therefore, the treating physician rule serves no particular purpose in the context of *de novo* review by the district court. *Id.* By implication, under the Second Circuit's holding, the treating physician rule is implied where the abuse of discretion standard of review applies. In *Conners*, the Second Circuit remanded the matter because the district court violated the commonsense starting point of the treating physician rule under the *de novo* standard.[4] The Second Circuit is consistent with the Ninth Circuit.

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[4] Additionally, the Second Circuit in *Conners* also found as error the district court's failure to recognize that the termination of benefits was not due to *medical change of condition* but rather a change in plan policy. *Conners*, at 136. In the present case the Ninth Circuit also found as error the Delta Plan's sudden termination of benefits without an allegation of a change in Frank Regula's medical condition. (*Pet. App.* 29a-30a); *see also McOsker v. Paul Revere Life Ins. Co.*, 279 F.2d 586, 589 (8th Cir. 2002) (unless information available to an insurer alters in some significant way, the previous payment of benefits is a

(Continued on following page)

**The Third Circuit Court Of Appeals**

The Third Circuit Court of Appeals issued a decision in *Skretvedt v. E.I. Dupont De Nemours And Co.*, 268 F.3d 167 (3rd Cir. 2001) applying the treating physician rule, and citing the Ninth Circuit's decision in present matter. *Id.*, at 184. In *Skretvedt* the court of appeals analyzed an application for disability benefits under ERISA and the abuse of discretion standard. The court of appeals summarily concluded without fanfare that:

> We have long recognized that in the analogous area of disability benefits determinations under the Social Security Act, the "opinions of a claimant's treating physician[s] are entitled to substantial and at times even controlling weight." *Fargnoli v. Massanari*, 247 F.3d 34, 43 (3rd Cir. 2001); *see also Cotter v. Harris*, 642 F.2d 700, 704 (3rd Cir. 1981); *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001).

*Id.* Therefore, the Third Circuit agrees with the Ninth Circuit's decision in the present matter.

Petitioner relies on the Third Circuit decision in *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 43 (3rd Cir. 1993), for the proposition that the Third Circuit conflicts with the Ninth Circuit. (*Pet.* at 22). In *Abnathya*, the Third Circuit did not reject the treating physician rule; it utilized it. *Abnathya* rejected the conclusory note of the

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circumstance that must weigh against the propriety of an insurer's decision to discontinue those payments); and *Carugati v. The Long Term Disability Plan For Salaried Employees*, No. 01-C5863, 2002 WL 441479, *8 (N.D. Ill. March 21, 2002).

treating physician in favor of the more detailed opinion of the examining physicians. *Abnathya,* 2 F.3d at 43. That is precisely how the treating physician rule is applied in practice. *(See Pet. App.* at 16a-17a (explaining that the deference given to the treating opinion under the rule is not absolute and subject to rejection based on the articulation of sufficient reasons supported by substantial evidence within the record)). Therefore, the Third Circuit in *Abnathya* applied a corollary doctrine of the treating physician rule, that conclusory opinions are not entitled to deference. The court of appeals simply applied the name to the doctrine in *Skretvedt*. The Third Circuit's decisions do not, as Petitioner alleges, deepen the split among the circuit courts of appeals. (*Pet.* at 22). Rather, the Third Circuit has incrementally adopted the treating physician rule. *See Skretvedt*, 268 F.3d at 184.

**The Fourth Circuit Court Of Appeals**

Petitioner and the dissent in the court of appeals decision rely upon the Fourth Circuit's decision in *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 608 (4th Cir. 1999), to find a conflict. (*Pet.* at 20-21 and *Pet. App.* 39a-40a (J. Brunetti, dissenting)). A fair reading of *Elliott* does not repudiate the treating physician rule. In *Elliott* the application of the treating physician rule to the facts of that case made no difference in light of the "persuasive contradictory evidence." *Id., citing Foster v. Heckler*, 780 F.2d 1125, 1130 (4th Cir. 1986) (finding that substantial contrary evidence existed to overcome any deference afforded a treating physician). The Fourth Circuit has clearly used the parameters of the treating physician rule to determine at least in the alternative that the rule's application had no

basis in fact to the case presented to it. *Elliott*, 190 F.3d at 608.

*Elliott* ignored the prior learned words in *Sheppard & Enoch Pratt Hospital, Inc. v. Travelers Insurance Company*, 32 F.3d 120, 126 (4th Cir. 1994). In the context of the doctor trying to obtain plan benefits, *Sheppard* declined to adopt the treating physician rule. *Sheppard & Enoch Pratt Hospital*, 32 F.3d at 126. In *Sheppard,* the treating physician had an obvious and material conflict, i.e., the payment of benefits directly to the doctors or medical care facility. *Id.* The court of appeals noted that the treating physician rule *is* appropriate when the application of that rule involves an assessment of whether the claimant is in fact disabled. *Id.* The Ninth Circuit dealt with the same issue finding that where evidence of "actual improprieties" exists, the fact finder is privileged to reject the opinions of the treating physician without further ado. *Saelee v. Chater*, 94 F.3d 520, 523 (9th Cir. 1996).

As the Ninth Circuit recognized in the present matter, the facts of *Sheppard* and the application of the treating physician rule are distinguishable when the issue is whether that rule applies in disputes over prescribed treatment, i.e., disputes over the payment of health care benefits directly to a physician rather then the receipt of disability benefits by the claimant. (*Pet. App.* 22a). The Ninth Circuit and the Fourth Circuit are complimentary. At most, there is an intra-circuit tension in the Fourth Circuit about the application of the treating physician rule to ERISA disability matters, between *Sheppard's* dictum and *Elliott's* observation that the rule would not change the outcome in that case.

**The Fifth Circuit Court of Appeals**

The dissent in the court of appeals and Petitioner rely upon the Fifth Circuit's decisions in *Dowden v. Blue Cross & Blue Shield of Texas, Inc.*, 126 F.3d 641, 644 (5th Cir. 1997) and *Salley v. E. I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992) (*Pet. App.* 39a-40a (J. Brunetti, dissenting) and *Pet.* at 20-21). The court of appeals held that application of the treating physician rule to the distinct facts of the cases was not appropriate.

The court of appeals in both cases declined to adopt the treating physician rule in the context of the doctor trying to obtain plan benefits. *Dowden*, 126 F.3d at 644 and *Salley*, 966 F.2d at 1016. In *Dowden* and *Salley,* the treating physicians had an obvious and material conflict, i.e., the payment of benefits directly to the doctors or medical care facility. *Id.* The Fifth Circuit stated that where such a conflict exists, the treating physician rule does not apply. *Salley* at 1016. The Ninth Circuit dealt with the same issue, finding that where evidence of "actual improprieties" exists, the fact finder is privileged to reject the opinions of the treating physician. *Saelee v. Chater*, 94 F.3d at 523.

But as the Ninth Circuit recognized in the present matter, the facts of *Dowden* and *Salley* where the treating physician rule was not applied, are distinguishable from the present case in that those cases involved disputes over the payment of health care benefits directly to a physician rather than the receipt of disability benefits by the claimant. (*Pet. App.* 22a). No conflict exists between the Ninth and Fifth Circuits on this issue; i.e., whether the treating physician rule applies in disability cases.

**The Eighth Circuit Court of Appeals**

The *Regula* dissent recognized that *Donaho v. FMC Corp.*, 74 F.3d 894, 899 (8th Cir. 1996) supports the proposition that the treating physician rule applies in the disability context of ERISA matters. (*Pet. App.* at 39a-40a (J. Brunetti, dissenting)). Petitioner ignores the Eighth Circuit's holding in *Donaho*. Petitioner rests considerable weight on the Eighth Circuit's later opinion in *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834 (8th Cir. 2001) (*Marshall*). *Marshall* raises two issues.

The first is whether *Marshall* could overturn *Donaho*. It cannot. *United States v. Franklin*, 250 F.3d 653, 665 (8th Cir. 2001) ("it is well established, however, that one panel of this court may not overrule another and so we must decline appellant's invitation to reconsider our prior decision").

The second question arising in *Marshall* is whether the Eighth Circuit expanded or constricted the incorporation of Social Security concepts into the ERISA disability paradigm. Careful analysis reveals that the Eighth Circuit expanded its incorporation of Social Security concepts. *Marshall*, 258 F.3d at 843 states:

> As we recently observed, however, a treating physician's opinion does "not automatically control, since the record must be evaluated as a whole." *Fletcher-Merrit* [*v. NorAm Energy Corp.*, 250 F.3d 1174, 1180 n. 3 (8th Cir. 2001)] (*citing Bentley v. Shalala*, 52 F.3d 784, 786 (8th Cir. 1995)).

The Eighth Circuit clearly adopted the treating physician rule in *Donaho*, 74 F.3d at 899. It is clear upon careful

reading of *Marshall* that the Eighth Circuit did not retreat from the pronouncement of the treating physician rule in *Donaho*, but instead continued to import the applicable tools from the Social Security decisional paradigm by citing *Bentley v. Shalala, supra*.

The holding in *Marshall* is consistent with the treating physician rule in its full regalia as understood and applied in the circuits. *See, e.g., Reddick v. Chater*, 157 F.3d 715, 720 (9th Cir. 1998) (rejecting the isolation of a quantum of evidence approach). The proposition is patent on the face of *Marshall* in any event; the court of appeals cited a Social Security case for the proposition that the treating physician rule is tempered by the need to review the record as a whole. *Marshall*, 258 F.3d 843 *citing Bentley v. Shalala*, 52 F.3d at 786. The Eighth Circuit has properly expanded its reliance on Social Security cases to develop the common law of ERISA.

The Eighth Circuit continues in its adoption and refinement of the treating physician rule in *Coker v. Metropolitan Life Ins. Co.*, 281 F.3d 793, 799 (8th Cir. 2002) (*citing* and *applying Donaho*, giving deference to treating physician, but finding that plan administrators properly rejected the treating opinions); *see also Conley v. Pitney Bowes*, 176 F.3d 1044, 1049 (8th Cir. 1999) (applying and finding that the rule is not that a treating physician opinion trumps all other evidence, but that a court must give it appropriate weight); and *Dodson v. Woodmen of the World Life Ins. Soc.*, 109 F.3d 436, 438 (8th Cir. 1997) (same).

There exists no conflict between the Eighth Circuit's decision in *Donaho* and the Ninth Circuit's decision in the present matter. The final informed analysis illustrates

that the Eighth Circuit continues to incorporate relevant concepts from the common law surrounding the Social Security Act's disability provisions into its ERISA jurisprudence.

**The Eleventh Circuit Court Of Appeals**

The Petitioner and the dissent rely upon the Eleventh Circuit's decision in *Jett v. Blue Cross and Blue Shield of Alabama*, 890 F.2d 1137, 1139 (11th Cir. 1989) (*Jett*), as evidence of conflict. (*Pet.* at 20-21 and *Pet. App.* at 39a (J. Brunetti, dissenting)). As the Ninth Circuit stated in its opinion, *Jett* involved medical eligibility for payment claim. (*Pet. App.* at 22a). *Jett* declined to adopt the treating physician rule in the context of a doctor trying to obtain plan benefits. *Jett*, 890 at 1138. As in *Salley* and *Dowden*, *Jett* holds the treating physician had an obvious and material conflict. *Id.* The Eleventh Circuit stated that where such a conflict exists, the treating physician rule does not apply. *Jett.* at 1138. The Ninth Circuit has dealt with the same issue finding that, where evidence of "actual improprieties" exists in the rubric of the treating physician rule, the fact finder is privileged to reject the opinions of the treating physician without further ado. *Saelee v. Chater*, 94 F.3d at 523. *Jett* does not represent the last word on the matter.

*Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321 (11th Cir. 2001) (*Levinson)* answers the question within the jurisdictional boundaries of the Eleventh Circuit where no evidence of impropriety exists. The court of appeals noted that the district court had given less weight to the opinion of a reviewing physician and more weight to the treating physician relying upon *Donaho.*

*Levinson*, 245 F.3d at 1329. The court of appeals affirmed the decision of the district court, including its reliance on *Donaho* in giving greater weight to the opinions of a treating physician than to that of an examining physician. *Levinson*, 245 F.3d at 1332. Judge Cox in partial dissent differed only in his view of the remedy, stating that he would remand for further consideration by the carrier of an unaddressed issue. *Levinson*, 245 F.3d at 1332-1333 (J. Cox, concurring in part and dissenting in part). Therefore, the entire panel agreed with the weight of the evidence assigned by the district court and its reliance upon *Donaho*. The Eleventh Circuit has thus affirmed the application of the treating physician rule in ERISA *disability benefit* cases in *Levinson*, which is distinguishable from its decision in *Jett*, dealing with the issue of the treating physician rule within the context of *health care benefits*.

Petitioner ignores the opinion in *Levinson*, failing to cite or discuss it in its petition. Rather, Petitioner relies on the recent Eleventh Circuit decision in *Turner v. Delta Family-Care Disability and Survivorship Plan*, No. 01-15450, 2002 WL 1040194 at *3-4 (11th Cir. May 24, 2002). (*Pet. App.* at 116a). The *Turner* decision is not binding precedent. *See Bonner v. City of Prichard,* 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc) (a later panel may not overrule an earlier panel decision, following the old Fifth Circuit rule).

The Eleventh Circuit in *Levinson* issued a panel decision, distinguishable on its face from *Jett*, affirming the use of the treating physician rule within the ERISA

context where the treating physician does not have an economic interest. That opinion is binding on the Eleventh Circuit.[5]

There exists no tension between the Eleventh Circuit's decision in *Jett* and the Ninth Circuit's decision in the present matter. At most, there is an intra-circuit tension in the Eleventh Circuit about the application of the treating physician rule to ERISA disability benefit matters, between the panel decisions in *Levinson* and *Turner*.

**Summation**

The Ninth Circuit Court of Appeals' decision in the present matter stands consistent with her sister circuit courts. The opinions of the circuit courts that have decided the issue of whether the treating physician rule applies to cases arising under ERISA in determining a claimant's eligibility for *disability benefits* have found that it does. The cases deciding whether under a claim for *health care benefits* the rule applies are also consistent throughout the

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[5] The Eleventh Circuit has commented further on the holding in *Bonner*, finding where an intra-circuit conflict of law exists, the earliest panel opinion is controlling. *See Leonard v. Enterprise Rent A Car*, 279 F.3d 967, 973 (11th Cir. 2002); *see also United States v. Dailey*, 24 F.3d 1323, 1327 (11th Cir. 1994). "The law of this circuit is 'emphatic' that only the Supreme Court or Eleventh Circuit Court of Appeals, sitting en banc, can judicially overrule a prior panel decision." *Cargill v. Turpin*, 120 F.3d 1366, 1386 (11th Cir. 1997), *cert. denied*, 523 U.S. 1080 (1998) *quoting United States v. Woodard*, 938 F.2d 1255, 1258 (11th Cir. 1991), *cert. denied*, 502 U.S. 1109 (1992); *see also Davis v. Estelle*, 529 F.2d 437, 441 (5th Cir. 1976) (one panel of this Court cannot disregard the precedent set by a prior panel, even though it conceives error in the precedent. Absent an overriding Supreme Court decision or a change in the statutory law, only the Court en banc can do this).

circuit courts. Universally, the circuits have held that where an actual impropriety exists the rule does not apply. Based on this distinction, no conflict exists among the decisions of the circuit courts of appeals. Petitioner has raised the mere apparition of a conflict that, upon close examination, is nothing more than miniscule intra-circuit tension fleshing out the body of the common law concepts.

## B

## PETITIONER'S CONTENTION THAT THE "TREATING PHYSICIAN RULE" IS INAPPLICABLE TO ERISA IS WITHOUT MERIT

Justice Kennedy said it best:

> The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference.

*Olmstead v. L.C.*, 527 U.S. 581, 610 (1999) (Kennedy, J., concurring in the judgment) (under the Americans with Disability Act).

Petitioner asserts that the Ninth Circuit's decision "borrows" a Social Security Act regulation that Congress did not intend to adopt for ERISA. (*Pet.* at 15-22). Petitioner is wrong.

The Ninth Circuit's unveiling of the treating physician rule is applicable to disability determinations arising under ERISA, is consistent with the Congressional mandate that the federal judiciary is charged with the development of a body of federal common law governing employee benefit plans. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 *citing* 120 Cong. Rec. 29942 (1974) (remarks of

Sen. Javits) ([i]t is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans); *see also Menhorn v. Firestone Tire Rubber Co.*, 738 F.2d 1496, 1499 (9th Cir. 1984). The Ninth Circuit's recognition that the "treating physician rule" may be utilized within the context of actions brought under ERISA is nothing more then the recognition, consistent with that of Justice Kennedy's, that treating physicians are entitled to deference. That deference is given to treating physicians because they are the ones who know the patient best and have had the greatest opportunity to observe the patient.

The court of appeals did not "borrow" the "treating physician rule." As recognized by the Ninth Circuit:

> It has long been settled among the circuit courts that disability determinations under SSA will be guided by the treating physician rule. *See Murray v. Heckler*, 722 F.2d 499, 501 (9th Cir. 1983) (joining the Second, Fifth, and Sixth Circuits in holding that the treating physician's opinions should be accorded greater weight than that of an examining or reviewing physician). The Social Security Administration subsequently codified the treating physician rule in its regulations governing disability determinations. *See* 20 C.F.R. § 404.1527(d), 416.927(d) (2001).

(*Pet. App.* at 19a). Therefore, contrary to Petitioner's assertion, it is the Social Security Administration that acquiesced to the concept of the treating physician rule from the common law, a rule and concept utilized by federal courts with respect to suits arising under the ADA,

Black Lung Act, Railroad Benefits Act, and Federal Tort Claims Act.[6]

Contrary to the implication of Petitioner's argument, Congress' failure to adopt the treating physician rule was not an affirmative decision. (*Pet. App.* at 15). Any "failure" of Congress to adopt the "treating physician rule," or any other specific regulatory scheme, cannot be said to be, or not be, an affirmative indication of that legislative body's intent. As recognized by the Ninth Circuit, Congress' failure to include the "treating physician rule" as a statutory construct, is not conclusive of its views on the issue. (*Pet. App.* at 19a-21a *quoting Firestone v. Bruch*, 489 U.S. at 114-115).

Indicative of Congress' realization that the bare terms, however detailed, of ERISA's statutory provisions would not be sufficient to establish a comprehensive regulatory scheme, it empowered the federal courts to develop, in the light of reason and experience, a body of federal common law governing employee benefit plans. *See Pilot Life*, 481 U.S. at 56; *see also Menhorn v. Firestone Tire Rubber Co.*, 738 F.2d at 1499.

Petitioner argues that the treating physician rule is inapplicable to ERISA because it affects a statute that Congress created to provide uniform standards as evidenced by its provisions preempting laws that relate to ERISA. (*Pet.* at 15). Petitioner misplaces its reliance on this Court's decision in *Pilot Life* to support its position. *Id.* While it is true that Congress specifically crafted

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[6] *See* cases cited *supra* note 2.

ERISA to preempt *state* law in order to create a uniform standard, it did nothing to preempt the ability of the federal courts to develop the federal common law and interpret the purposes of the statute. *See supra,* Argument B, pp. 24-26; *see also Pet. App.* 21a.[7] This Court recognized long ago that Congress expected a body of federal substantive law be developed by the federal courts to deal with issues involving rights and obligations under private welfare and pension plans. *Pilot Life*, 481 U.S. at 56 *citing* 120 Cong. Rec. 29942. Therefore, the Ninth Circuit opinion follows the same analysis as recognized in *Pilot Life*, and applied in *Firestone v. Bruch*, in determining the issue in the present case. (*Pet. App.* at 20a-21a).

Petitioner criticizes the Ninth Circuit opinion as improperly diminishing the deference as described by *Firestone v. Bruch*. (*Pet.* at 16-17). Petitioner's contention ignores this Court's most recent interpretation of *Firestone v. Bruch,* and its grant of discretion in *Rush Prudential HMO, Inc. v. Moran,* 2002 DJDAR at 6905 and 6905 fn. 15. This Court held that standards for reviewing benefit determinations should be read to require a uniform judicial regime of categories of relief and standards of primary conduct, not a uniformly lenient regime of reviewing benefit determinations. *Id.* This Court further remarked that discretion is diminished where a conflict of interest exists or is plausibly raised. *Id.*, at fn.15. The Ninth Circuit's prophetic analysis in its decision regarding the amount of discretion afforded a conflicted plan is

[7] No case has ever held that ERISA preempts federal law, displaces federal law where applicable, or otherwise frees an ERISA plan from intelligent development of a common law as fashioned by the courts.

consistent with this Court's decision in *Rush*. *Compare*, *Pet. App.* 20a-22a *with Rush Prudential HMO, Inc. v. Moran*, 2002 DJDAR at 6905 and 6905 fn. 15.

Petitioner also argues that the court of appeals' decision in this case draws an unreasonable distinction between health benefit cases and disability benefit cases with respect to the credibility of physicians. (*Pet.* 18). Petitioner argues that, under either system, a physician is under an incentive to commit fraud and issue an unsubstantiated opinion in favor of a claimant. *Id.* Petitioner relies on *Pegram v. Herdrich*, 530 U.S. 211, 218 (2000) for the proposition that, in a fee for service system, the incentive for the physician is on more care. *Id.*

Petitioner's reliance on *Pegram* and its citation of that decision to this court are incomplete. Justice Souter, in delivering the opinion for a unanimous court, discussed the difference between fee for service medical care and the care provided in Health Maintenance Organizations (HMO). *Pegram v. Herdrich*, 530 U.S. at 218. While this Court did recognize that under a fee for service arrangement the physician's incentive would be to provide more care, this court stated that the "check on this incentive is a physician's obligation to exercise reasonable medical skill and judgment in the patient's interest." *Id.* Therefore, this Court rejected the opportunity to characterize the medical profession as one whose members would risk their license by fraudulently filling out continuing disability reports required by the Delta Plan for a mere pittance of payments.

Petitioner's final position is that the Ninth Circuit's decision mandates that the Delta Plan follow and incorporate the paradigm of the Social Security Act in total. *Pet.* 18-20. This is only the mere dust of an argument. As demonstrated *supra*, the treating physician rule is not a creature of the Social Security Act. It is a judicially uncovered concept made applicable by discovery of the common law. Nothing in the decision of the court of appeals requires ERISA plans to adopt or follow the Social Security Act or regulations. The Ninth Circuit merely recognizes, as this Court did with respect to the ADA, and as the federal judiciary has with respect to cases under the Black Lung Act, Railroad Benefits Act, FTCA, and the Social Security Act, that treating physicians are entitled to deference because they are in the best position to offer a cinematic medical opinion in comparison to the snapshot that a one-time examiner may offer of an individual's condition.[8]

Petitioner ignores the fundamental underpinning of the treating physician rule as it was engrafted into the decision-making process by judicial unveiling in *Murray v. Heckler*, 722 F.2d 499, 501 (9th Cir. 1983). *Murray* joined three other circuits in recognizing the proper application of the treating physician rule before it became universally acknowledged and finally incorporated into the Social Security regulations and rulings. *Murray* acknowledged the treating physician rule, stating:

> We note also that the Fifth Circuit has joined the Second and Sixth Circuits in giving greater

[8] *See* cases cited *supra* note 2.

> weight to the opinions of treating physicians. *See Bowman v. Heckler*, 706 F.2d 564, 568 & n. 3 (5th Cir. 1983). In *Bowman*, as in this case, "[t]he ALJ did not attempt to resolve the conflict in the testimony of the two [doctors]. . . . " *See* 706 F.2d at 568. The Fifth Circuit gave greater weight to the testimony of the treating physician because of the purpose for which he or she was employed: "Our reliance on the opinion of the treating physician is based not only on the fact that he is employed to cure but also on his greater opportunity to observe and know the patient as an individual." *Id.* We agree.

*Murray, supra.*

The treating physician has a greater pool of knowledge because of the longitudinal history with the patient and gathered knowledge for the purpose of improving the patient's health. The examining physician called upon by a plan or insurance company does so briefly and for the sole purpose of fulfilling the request for an opinion. The examining physician has a smaller pool of knowledge and the purpose for his information gathering is impure *ab initio*. Those reasons constitute why the courts invoked the treating physician rule in Social Security cases and other paradigms,[9] and that is why it applies here, as a matter of commonsense starting point. The treating physician rule does not rest upon calling one set of physicians ethical and branding the other set as not. Rather, the treating physician rule rests on a foundation of knowledge and purpose for which the knowledge was gathered in the first place.

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[9] *See* cases cited *supra* note 2.

The Ninth Circuit's decision does not incorporate the Social Security Act into the ERISA context. The treating physician rule is not an absolute, requiring a plan to give a treating physician controlling authority; it is merely the common sense recognition, as articulated by Justice Kennedy in *Olmstead v. L.C.*, that a treating physician opinion is entitled to deference. *Olmstead v. L.C.*, 527 U.S. at 610. A treating physician is afforded deference because he has a greater opportunity to "know and observe the individual as a whole." (*Pet. App.* at 15a *quoting Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999)). As the court of appeals found, such deference is warranted under a statute, "the purpose of which is at least in part 'to promote the interests of employees and their beneficiaries.'" (*Pet. App.* at 17a *quoting Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983)). Therefore, the "treating physician rule" is properly found within ERISA.

## C

## NO CONFLICT EXISTS REGARDING THE "CONFLICT OF ISSUE" ISSUE

Petitioner argues that the court of appeals has gone beyond this Court's holding in *Firestone v. Bruch*, *supra*, in finding a *per se* conflict of interest where the same entity funds and administers the plan. (*Pet.* at 23-26). The Petitioner errs. The Ninth Circuit's decision is consistent with this Court's analysis in *Firestone* and its most recent interpretation of that case. *Compare*, *Pet. App.* 20a-22a and 24a-31a *with Rush Prudential HMO, Inc. v. Moran*, 2002 DJDAR at 6905 and 6905 fn. 15.

As the court of appeals recognized, a plan that establishes a trust, whether irrevocable or revocable, does not create a true trust where the plan both funds and administers the plan. (*Pet. App.* at 26a). Therefore, the Ninth Circuit's holding that Petitioner operates under a conflict of interest based on its dual role, is consistent with this court's pronouncement that a plausibly raised conflict suffices to examine the deference afforded in reviewing a plan's decision. *Rush Prudential HMO, Inc. v. Moran, supra.* The court of appeals also found that where the plan has failed to rebut a properly raised conflict, demonstrating that its decision to deny or terminate benefits was not infected by the conflict it is operating under, the court reviews *de novo* the decision of the plan administrator. (*Pet. App.* at 27a *citing Termain v. Bell Industries, Inc.*, 196 F.3d 970, 976 (9th Cir. 1999)). This holding is not a new standard. *See Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1322 (9th Cir. 1995). It is also consistent with the other circuit courts of appeals. *Id.*, (discussing the approach other circuits utilize when confronted with a plan operating under a conflict of interest that has infected the plan determination). It is also consistent with this Court's own observation in its recent decision in *Rush Prudential HMO v. Moran, supra. See Rush*, 2002 DJDAR at 6905 fn. 15 ("it is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest").

No conflict exists amongst the circuits on this issue. When the plan operates under a plausible conflict of interest, courts review that decision of the plan with a wary eye. *Id.* Clearly, the Ninth Circuit's holding merely anticipated the observations of this Court in *Rush*.

## IV

## CONCLUSION

There exists no conflict between the Ninth Circuit's decision and the other circuit courts. The Ninth Circuit's application of the treating physician rule is consistent with this Court's and the Circuit Courts' utilization of that rule throughout the body of federal law and effectuates the purpose of ERISA, to protect the rights of participants and beneficiaries. Further, the Ninth Circuit's opinion is consistent with the Congressional mandate that the federal judiciary is charged with the development of a body of federal common law. For all the forgoing reasons, Respondents respectfully request that this Honorable Court deny the Petition.

Respectfully submitted,

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In The

# Supreme Court of the United States

October Term, 2002

DELTA FAMILY-CARE DISABILITY AND SURVIVORSHIP PLAN,

*Petitioner*,

v.

FRANK REGULA,

*Respondent*.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

## MOTION OF THE ERISA INDUSTRY COMMITTEE FOR LEAVE TO FILE AND BRIEF AMICUS CURIAE IN SUPPORT OF THE PETITION FOR CERTIORARI

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On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

**MOTION OF THE ERISA INDUSTRY COMMITTEE FOR LEAVE TO FILE A BRIEF AMICUS CURIAE IN SUPPORT OF THE PETITION FOR CERTIORARI**

The ERISA Industry Committee ("ERIC") moves, pursuant to Rule 37.2, for leave to file the attached brief *amicus curiae* in support of the petition for writ of certiorari in this case. While the petitioner has consented to the filing of this brief, respondent Frank Regula has not consented. Correspondence reflecting the consent of the petitioner has been lodged with the Court.

ERIC is a nonprofit organization representing America's largest private employers that maintain ERISA-covered pension, healthcare, disability, and other employee benefit plans, providing benefits to millions of active workers, retired persons, and their families nationwide. All of ERIC's members do business in more than one State, and many have employees in all fifty States. ERIC frequently participates as amicus in cases with the potential for far-reaching effect on employee benefit plan design or administration.[1]

ERIC and its members have a vital interest in this case, which will affect in two ways how claims for benefits are administered. First, the decision below imports into the disability plans administered by private employers the "treating physician rule" used in determining disability claims under Titles II and XVI of the Social Security Act. Second, it holds that if a company's employees serve on a committee deciding benefit claims, there is a per se conflict of interest. Both holdings deprive employers of the discretion afforded them under ERISA with respect to plan design and plan administration. If allowed to stand, the decision below will cause additional expense in the administration of plans, to the detriment of both employers and employees, and will create uncertainty by imposing different rules in the Ninth Circuit than elsewhere in the country.

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[1] *See, e.g., Hughes Aircraft Co. v. Jacobson,* 525 U.S. 432 (1999); *Lockheed Corp. v. Spink,* 517 U.S. 882 (1996); *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989); *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58 (1987).

Because of the importance of these issues to ERIC and its members, ERIC moves for leave to file this brief to assist the Court in its consideration of the petition.

Respectfully submitted,

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## BRIEF OF THE ERISA INDUSTRY COMMITTEE AS *AMICUS CURIAE* IN SUPPORT OF THE PETITION FOR CERTIORARI

The ERISA Industry Committee ("ERIC") respectfully submits this brief *amicus curiae* in support of the petition for a writ of certiorari in this case.[1]

## INTEREST OF AMICUS CURIAE

The interest of ERIC and its members is set forth in the foregoing Motion for Leave to File.

## INTRODUCTION

Both questions presented in the petition for certiorari raise important issues of ERISA interpretation that affect how benefit plans are administered—issues on which the courts are divided and with respect to which the Ninth Circuit opinion cannot be reconciled with the statute and implementing regulations. The court of appeals' ruling below improperly circumscribes the broad discretion ERISA accords to private employers to design and administer the disability benefit plans that they offer to their employees. If allowed to stand, the decision below is sure to create additional expense in the administration of plans, to the detriment of both the employers and employees whose contributions fund them.

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[1] Pursuant to Rule 37.6, amicus states that no counsel for any petitioner or respondent authored this brief in whole or in part. No person or entity, other than ERIC and its members, made a monetary contribution to the preparation or submission of this brief.

The Department of Labor has recently completed a major review and overhaul of its regulations governing claims procedures for group health and disability plans, including the process for review of adverse benefit determinations and the need for medical consultations. Those regulations strive to reconcile "the need for procedural protections with the purely voluntary nature of the system through which these vital benefits are delivered." 65 Fed. Reg. 70246, 70246 (Nov. 21, 2000). The newly promulgated rules do not require plans to defer to a claimant's treating physician, nor do they prohibit the employees of a plan sponsor from serving on the benefit committees that review claims. Nonetheless, the decision below has effectively rewritten the governing standards—at least for States in the Ninth Circuit—to include both of those provisions. The result is not only inconsistent with ERISA but it subjects plans to differing standards depending on the court reviewing the claim, contrary to the statute's commitment to uniform national standards.

## STATEMENT

1. The Employee Retirement Income Security Act ("ERISA") was enacted in 1974 to "safeguar[d] . . . the establishment, operation, and administration" of employee benefit plans by setting "minimum standards . . . assuring the equitable character of such plans and their financial soundness." 29 U.S.C. 1001(a). The statute does not require employers to establish employee benefit plans, nor does it define the benefits that must be provided or the method of calculating those benefits. *See Lockheed v. Spink*, 517 U.S. 882, 885 (1996); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981). Instead, ERISA regulates employers that choose to offer employee benefits to ensure that

employees actually receive the benefits described in their plans. In furtherance of that goal, Section 503 of ERISA delegates to the Department of Labor the authority to promulgate rules that will "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." ERISA § 503, 29 U.S.C. § 1133.

Pursuant to Section 503, the Department of Labor recently overhauled the regulations governing the processing of benefit claims under ERISA-covered disability plans, effective for all claims filed after January 1, 2002. *See* 65 Fed. Reg. at 70246. The new standards for handling disability claims are "intended and expected to improve the timeliness and accuracy of disability benefit claims determinations," "increase enrollee confidence in disability plans," and "promote efficiency in disability insurance and labor markets." *Id.* at 70261. As a general rule, an ERISA-covered disability plan must "contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants." *Id.* at 70266.

Among other things, the new rules provide that a claimant must have (i) the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits, upon request and free of charge; and (iii) a review that takes into account all comments, documents, records, and other information

submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. 29 C.F.R. § 2560.503-1(h)(4).

In addition, claimants have the right to appeal an adverse benefit determination to an appropriate named fiduciary of the plan. If the determination is based "in whole or in part on a medical judgment," the fiduciary must "consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment." A consulting health care professional cannot have been consulted in connection with the adverse benefit determination that is the subject of the appeal, nor be the subordinate of any such individual. 29 C.F.R. § 2560-503-1(h)(3)(iv-v).

2. According to the Department of Labor, 36 million U.S. private-sector employees (or 32 percent of all such employees) are insured against short-term disability through employer-sponsored plans, and 26 million (or 23 percent) are insured against long-term disability. 65 Fed. Reg. at 70261. The Department of Labor also estimates that there are some 1,716,000 disability plans operating in the United States, and that together they process 1,389,700 claims a year, of which the overwhelming majority (1,304,900) are approved. *Id.* at 70263.

3. Separate and apart from private employer-sponsored disability plans, there are a number of government disability programs, including Social Security Disability Insurance ("SSDI") and Supplemental Security Income ("SSI"), both of which are administered by the Social Security Administration ("SSA").

SSDI is a component of the Social Security Old-Age, Survivors, and Disability Insurance ("OASDI") program. *See* Title II of the Social Security Act; 42 U.S.C. §§ 401 - 433. The program is financed by employer and employee payroll taxes. SSDI coverage is widespread with approximately 90 percent of workers aged 21 to 62 protected in the event of long-term severe disability. *See* OASDI Fact Sheet (visited June 30, 2002) <http://www.ssa.gov/OACT/FACTS/fs2002_06.html>. In calendar year 2001, approximately 1.5 million claims for disability benefits were filed, with benefits being awarded in 46.1 percent of cases. *See* Selected Data from Social Security's Disability Program (visited July 16, 2002) <http:// www.ssa.gov/OACT/STATS/dibStat.html>.

SSI is a nationwide federal assistance program that guarantees a minimum level of income for needy aged, blind, or disabled individuals without regard to past contribution. *See* Title XVI of the Social Security Act; 42 U.S.C. §§ 1381 - 1383d. In calendar year 2001, there were approximately 1.5 million new applications and 665,000 new entrants for benefits based on blindness or disability. *See* 2002 SSI Annual Report (visited July 16, 2002) <http://www.ssa.gov/OACT/SSIR/SSI02/Participants_1.html#405005>.

For both SSDI and SSI, determinations of disability are made based on a five-step sequential evaluation process set forth in SSA regulations. *See* 20 C.F.R. §§ 404.1520, 416.920. Both programs also adhere to the following principle, known as the "treating physician rule":

> Generally, we give more weight to opinions from your treating sources . . . . If we find that a treating source's opinion on the issue(s)

> of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply [various factors presented in the regulations] in determining the weight to give the opinion.

20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2).[2]

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[2] The "treating physician" rule originated in the courts reviewing appeals from SSA determinations, and was premised on the Social Security Act being "a remedial statute, to be broadly construed and liberally applied." *Gold v. Secretary of Health, Educ. and Welfare*, 463 F.2d 38, 41 (2d Cir. 1972) (quoting *Haberman v. Finch*, 418 F.2d 664, 667 (2d Cir. 1969)). It was adopted by the SSA only upon injunction from the U.S. Court of Appeals for the Second Circuit. *See Schisler v. Sullivan*, 3 F.3d 563, 567-68 (2d Cir. 1993) (reciting history).

## REASONS FOR GRANTING THE WRIT

### I. The Decision Below Creates A Division in The Lower Courts, Uncertainty in Plan Administration, And Questionable Precedent That Calls For Immediate Review By This Court.

#### A. The Ninth Circuit's Importation of the SSA's Treating Physician Rule Into ERISA Is Improper and In Conflict With Other Circuits.

In the decision below, the panel majority, desirous of "consistency in [its] review of disability determinations" could find "no reason why the treating physician rule should not be used under ERISA." *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1139 (9th Cir. 2001). That is tantamount to declaring that for the convenience of the court, all apples shall henceforth be considered as oranges. While both ERISA and the SSA involve disability programs subject to federal court review, their statutory and regulatory schemes are by no means interchangeable, and the presumptions that apply to one are inappropriate for the other.

The overriding principle of ERISA is that benefits are governed by the language of the plan itself. *See Firestone*, 489 U.S. at 115. Requiring all employers to abide by the treating physician rule despite the uniqueness of each plan is precisely what ERISA is not intended to do. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985) (ERISA does not "regulate the substantive content of welfare-benefit plans."). ERISA neither contemplates nor requires a mandatory application of the

treating physician rule. Rather, ERISA requires basic procedural safeguards in the determination of benefit plans and appeals. *See* 29 U.S.C. § 1133.

ERISA does give the Department of Labor the authority to promulgate general regulations governing the processing of benefit claims, including disability claims. Those regulations, just recently updated, do not impose a treating physician standard, although the Department is clearly familiar with the rule since it adopted that standard for Black Lung cases in regulations published just a few weeks later. *See* 65 Fed. Reg. 79920 (Dec. 20, 2000). Instead, the Department requires consultation with "an appropriate health care professional." 29 C.F.R. § 2560-503-1(h)(3)(iv-v). Subsequent guidelines issued by the Department explain that the requirement of consultation "is intended to ensure that the fiduciary deciding a claim involving medical issues is adequately informed as to those issues." The guidelines go on to state that "[i]n all cases, a fiduciary must take appropriate steps to resolve the appeal in a prudent manner, including acquiring necessary information and advice, *weighing the advice and information so obtained*, and making an *independent* decision on the appeal." Benefit Claims Procedure Regulation FAQ, U.S. Dept. of Labor Q-D8 ("BCPR") (visited July 16, 2002) <http://www.dol.gov/pwba/FAQs/faq_claims_proc_reg.html > (emphasis added).

The Department has concluded that its regulation strikes the appropriate balance between the need for "accuracy," "enrollee confidence in disability plans," and "efficiency in disability insurance and labor markets." 65 Fed. Reg. at 70261. As its subsequent guidance explains:

> The Department did not intend to prescribe any particular process or safeguard to ensure and verify consistent decision making by plans. To the contrary, the Department intended to preserve the greatest flexibility possible for designing and operating claims processing systems consistent with the prudent administration of a plan.

BCPR Q-B4 (visited July 16, 2002) <http://www.dol.gov/pwba/FAQs/faq_claims_proc_reg.html>.

The Department of Labor's interpretation of the proper balance between plan flexibility and required procedures is instructive, even though the particular claim at issue was processed prior to the new regulations being in effect. As one of the agencies tasked with implementing ERISA, the Department's reasonable interpretation of the procedures necessary for claims processing are entitled to deference. *See Massachusetts v. Morash*, 490 U.S. 107, 116 (1989). The Ninth Circuit has now usurped the flexibility that the Department of Labor sought to protect by requiring plans to accept the opinion of a claimant's treating source as presumptively correct rather than, for example, basing a decision on the totality of the record. A departure from this flexibility that requires application of the treating physician rule in all cases is certain to create additional expense in plan administrative costs.[3]

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[3] These costs are not borne solely by employers. Because of the favorable tax consequences to benefit recipients, many disability plans are funded through after-tax employee

Although the panel majority could see "no reason" not to import the treating physician rule into its review of claims brought under ERISA, one need look no farther than the difference between the SSDI and SSI government plans—which are "to be broadly construed and liberally applied," *Gold v. Secretary of HEW*, 463 F.2d 38, 41 (2d Cir. 1972)—and the discretion ERISA accords employers to design their own plans. In a similar context, the New York Court of Appeals held that application of the treating physician rule would be inappropriate in the Medicaid program because that program "confers broad discretion on participating States to determine the extent of services provided." *See Kuppersmith v. Dowling*, 710 N.E.2d 660, 662 (N.Y. 1999). Accordingly, the court rejected a class challenge to State Medicaid regulations on the ground that they did not accord sufficient weight to treating physicians' assessment of the scope of home health care services that must be provided in specific cases.

Similarly, in *White v. Principi*, 243 F.3d 1378, 1379 (Fed. Cir. 2001), the Federal Circuit rejected the argument that the Court of Appeals for Veterans Claims had "erred as a matter of law when it failed to adopt the 'treating physician' rule, which would require that additional evidentiary weight be given to the opinion of a physician who had treated her husband." The Federal Circuit found that the treating physician rule was "specifically designed" to address conflicts of opinion inherent in the Social Security disability determination process. *See id.* at 1380. Moreover, the court found that while the treating physician rule was

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contributions. *See* Ken McDonnell, *Disability Income: Voluntary Employment-Based Plans* 9 (EBRI Notes June 2002).

consistent with the statutory scheme of Social Security, according additional weight to any one factor may conflict with a statute providing that Veterans Benefits determinations should be made on the basis of entire record. *See id.* at 1381 (citing 38 U.S.C. § 7104(a)). *See also Knudsen v. Department of Health and Human Servs.*, No. 90-2067V, 1992 WL 395631, at *6-*7 (Fed. Cl. Dec. 17, 1992) (holding that treating physician rule conflicts with National Vaccine Injury Compensation Program regulations requiring fact finder to consider entire record).

As these decisions recognize, it is the structure of the program in question that should dictate application of common law presumptions. Applying that reasoning to ERISA, two circuits have considered, and rejected, application of the treating physician rule in cases involving the very same benefit plan at issue in this case. The Eighth Circuit held that the treating physician rule could not apply to the Delta plan because "the record must be evaluated as a whole." *See Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834, 842 (8th Cir. 2001); *see also Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270, 1274 (11th Cir. 2002) (per curiam).

The rule has also been rejected in the Fourth, Fifth, and Seventh Circuits, and in the Sixth Circuit in an unpublished opinion. *See Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607-08 (4th Cir. 1999); *Dowden v. Blue Cross & Blue Shield of Tex., Inc.*, 126 F.3d 641, 644 (5th Cir. 1997); *Wilczynski v. Kemper Nat'l Ins. Co.*, 178 F.3d 933, 938 (7th Cir. 1999); *Jackson v. Metropolitan Life*, No. 01-5028, 2001 WL 1450811, at *2 (6th Cir. Oct. 29, 2001). The Second Circuit, however, has suggested that in circumstances where the plan administrator is accorded discretion, as is the case

here, it may find application of the rule appropriate. *See Connors v. Connecticut General Life Ins. Corp.*, 272 F.3d 127, 135 n.3 (2d Cir. 2001).

Permitting the Ninth Circuit's application of the treating physician rule in reviewing ERISA-governed claims for disability benefits would undermine the need for plan and administrative uniformity that is fundamental to ERISA. Without review of this case by this Court, benefit plans such as that sponsored by Delta are likely to be construed one way in the States of the Ninth, and possibly the Second, Circuits, and another in the States of those Circuits that have explicitly rejected application of the treating physician rule to ERISA-governed disability benefit claims. For the reasons given in Part II, *infra*, the lack of uniformity creates an intolerable situation for employers with multi-state operations.

### B. The Ninth Circuit's Holding That Employee Involvement in Benefit Determinations Is a Per Se Conflict Is Incorrect and In Conflict With Decisions From Other Courts.

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court addressed the standard of review for actions, such as this one, in which plan participants bring suit under ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), claiming that they have been denied benefits to which they are entitled under the terms of a plan governed by ERISA. Following trust law principles, the Court held that a deferential standard of review is appropriate when the plan administrator or other fiduciary is authorized to exercise discretionary power to construe the



terms of the plan. *Id.* at 115. The Court also stated that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)).

The decision below exacerbates and highlights the disagreements among the federal appeals courts as to whether and to what extent the involvement of a plan sponsor's employees constitutes a conflict of interest that deprives fiduciary decisions of the *Firestone* standard of review. The court held that a substantial conflict of interest exists whenever a plan sponsor's employees participate in deciding benefit claims, and went on to hold that the decision not to endorse the opinion of the treating physician was evidence that the fiduciaries may have been acting out of self-interest. The Court concluded that it was therefore required to review the decision to discontinue benefits *de novo*, rather than applying the deferential standard called for by *Firestone*. *See* 266 F.3d at 1145.

The Ninth Circuit's extreme position—that employee administration establishes a per se conflict requiring *de novo* review of benefit denials—incorrectly applies the standard of review that was developed to address what was perceived to be an inherent conflict when an insurance company administers claims under a policy it issued. *See Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995)). The reasoning of that line of cases is that "[b]ecause an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business." *Brown v. Blue Cross and Blue Shield of Ala., Inc.*, 898 F.2d

1556, 1561 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991).

In contrast to other Circuits, the Ninth Circuit now applies that rule even in situations where disability coverage is funded through assets that by definition cannot revert to the employer, *see* 26 U.S.C. § 501(c)(9), 26 C.F.R. § 1.501(c)(9)-4(a),(d), as is frequently the case with employer-sponsored disability plans. *See* 2 Jeffrey D. Mamorsky, Employee Benefits Handbook ¶ 38.05[3] (1999). The Internal Revenue Code imposes a sanction of 100% if any such contributions revert to the plan sponsor. 26 U.S.C. § 4976. As the Eleventh Circuit has held in a decision involving the very same Delta plan, such funding structures "eradicate[] any alleged conflict of interest," which means that the *Firestone* standard of review should apply. *Turner*, 291 F.3d at 1273 (citing *Buckley v. Metropolitan Life*, 115 F.3d 936 (11th Cir. 1997)). Similar conclusions are reflected in decisions of the Third, Seventh, and Tenth Circuits. *See Abnathya v. Hoffmann-La Roche Inc.*, 2 F.3d 40, 45 n.5 (3d Cir. 1993); *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1097-98 (10th Cir. 1999) (citing *Woolsey v. Marion Labs., Inc.*, 934 F.2d 1452, 1459 (10th Cir. 1991)).

The decision below is not only in conflict with those of the other Circuits, it also cannot be reconciled with basic ERISA principles. ERISA expressly permits a sponsor to appoint its own officers, employees, agents, and other representatives to serve as fiduciaries, *see* 29 U.S.C. § 1108(c)(3), *Firestone*, 489 U.S. at 105, and defines the roles of administrator and fiduciary in a manner that permits employees to serve in those positions, *see* 29 U.S.C.

§ 1002(16)(A)(i-ii) (defining "plan administrator" as "person specifically so designated by the terms of the instrument" or by the plan sponsor); § 1002(21)(A) (defining "fiduciary"). Sponsor employees who serve as administrators and fiduciaries are bound to discharge their duties solely in the interest of participants and beneficiaries. 29 U.S.C. § 1104(a). In exercising those responsibilities, among other things, employers and employees called upon to make or review benefit determinations must ensure that plan provisions are "applied consistently with respect to similarly situated claimants" and must follow the new Department of Labor regulations requiring consultation with an appropriate health care professional. 29 C.F.R. § 2560-503.1(h)(3).[4]

The Court should grant certiorari in order to re-establish uniformity among the Circuits and to articulate a standard of review that, unlike the decision below, is consistent with ERISA, its implementing regulations, and this Court's precedents.

## II. ERISA's Goal of National Uniformity Cannot Be Met As Long As Employers Are Subject to Conflicting Standards.

The Court should not await further development of these issues among the courts of appeals, because the decision below has already resulted in an untenable lack of

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[4] Courts have also recognized that employers have economic incentives to provide the benefits set forth in their plan. *See Gallo v. Amoco Corp.*, 102 F.3d 918, 921 (7th Cir. 1996). Tne fact that most disability benefit claims for employer plans are approved, while most claims for SSDI and SSI benefits are not, suggests that these incentives are effective. *See supra* pp. 4, 5.

consistency for employers that administer multi-state benefit plans. The importance of national uniformity in ERISA plan regulation is acute. Without it, employers cannot provide a uniform system of benefits to their workforce. Until this Court resolves the conflict among the lower courts, employers cannot have any confidence that benefit determinations will be treated uniformly in the various States in which they have operations.

This Court has repeatedly stated that one of the primary purposes behind ERISA's enactment was to achieve uniformity in pension plan regulation. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (holding that ERISA's preemption provision "was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law" and that "[o]therwise, the inefficiencies created could work to the detriment of plan beneficiaries"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983) ("By establishing benefit plan regulation 'as exclusively a federal concern,' Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees.") (citation omitted). On the questions presented in this case, the patchwork system of regulation that Congress sought to avoid with ERISA's enactment is continuing, not because of varying state laws but because of different interpretations of federal law advanced in the federal circuit courts.

The court of appeals' adoption of the treating physician rule and its application of a heightened standard of review based on employee-administered plans undermine ERISA's goal of creating a "uniform administrative scheme." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987); H.R. Rep. No 93-533, at 12 (1974), *reprinted in*

1974 U.S.C.C.A.N. 4639, 4650 ("The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws."). No other Circuit has adopted the treating physician rule in the ERISA context. No other Circuit has applied as searching a level of review based solely on the administration of the plan by the sponsor's employees. If the decision below is permitted to stand, plans covering employees in different States will be subject to conflicting rules.

The conflict among the Circuits is only exacerbated by ERISA's venue provision, which permits suit to be brought in any district where a defendant resides or may be found, or where the alleged breach took place, or where the plan is administered. *See* 29 U.S.C. § 1132(e)(2). It is not uncommon for an employer to find itself sued in a judicial district where it has never done business, simply because a former employee has moved or retired there. ERISA's permissive venue provision therefore invites forum shopping when the Circuits apply different interpretations of the statute, as they have here.

## CONCLUSION

For all of these reasons, as well as those set forth in the petition, amicus respectfully urges the Court to grant the petition for certiorari to review both questions presented in this case.

Respectfully submitted,

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No. 01-1840

IN THE

# Supreme Court of the United States

DELTA FAMILY-CARE DISABILITY AND SURVIVORSHIP PLAN,

*Petitioner*,

v.

FRANK REGULA,

*Respondent*.

**On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit**

## MOTION OF BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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## MOTION OF BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

The Bert Bell/Pete Rozelle NFL Player Retirement Plan ("NFL Player Retirement Plan" or "Plan") hereby respectfully moves for leave to file the attached brief *amicus curiae* in this case. The consent for the attorney for petitioner has been obtained. The consent of the attorney for the respondent was requested but refused.

The NFL Player Retirement Plan benefits present and former players in the National Football League ("NFL"). The Plan is maintained under collective bargaining agreements between the NFL Management Council, the bargaining representative of the NFL clubs, and the National Football League Players Association, the bargaining representative of the NFL players. The Plan provides disability benefits to

players who become totally disabled during the course of their playing careers and to former players whose total disabilities arise after their playing careers have ended.

In the instant case, the court of appeals ruled that disability benefit plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA") must apply the "treating physician" rule applicable to the adjudication of claims for Social Security disability benefits when determining eligibility for disability benefits under private, employer-sponsored benefit plans. The treating physician rule is embodied in a regulation promulgated by the Social Security Administration and is designed for the purposes of the public Social Security program. The imposition of this rule on private employee benefit plans subject to an entirely different regulatory regime administered by a different federal agency represents an unwarranted interference with the Congressional objectives embodied in ERISA.

Six other courts of appeals have considered and rejected the notion that the treating physician rule should apply to ERISA disability plans. Following the Ninth Circuit's decision in this case approving the rule, one other circuit has joined the Ninth Circuit's minority position. This conflict threatens to impose incompatible standards of conduct on the large number of plans that provide disability benefits to participants throughout the United States. The NFL Player Retirement Plan, whose participants can be found in every federal circuit, and which is often involved in litigation concerning disability benefits in courts all over the country, believes that its experience with the administration of a complex and carefully developed plan of disability benefits can provide the Court with additional insight into the problems inherent in the Ninth Circuit's decision.

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## BRIEF *AMICUS CURIAE* OF BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

## INTEREST OF THE *AMICUS CURIAE* [1]

The Bert Bell/Pete Rozelle NFL Player Retirement Plan ("NFL Player Retirement Plan" or "Plan") benefits present and former players in the National Football League ("NFL").

[1] Pursuant to Rule 38.6, (1) counsel for a party to this case has not authored this brief in whole or in part, and (2) no person or entity other than the *amicus curiae* has made a monetary contribution to the preparation or submission of this brief.

The Plan is maintained under collective bargaining agreements between the NFL Management Council ("NFLMC"), the bargaining representative of the NFL clubs, and the National Football League Players Association ("NFLPA"), the bargaining representative of the NFL players.

In addition to pension benefits, the NFL Player Retirement Plan provides disability benefits to eligible players. Vested Players who are unable to work, under the terms of the Plan, receive total and permanent disability benefits until they reach the Plan's normal retirement age of 55. These benefits are paid even if the player's disability is not related to football and even if the player becomes unable to work decades after his NFL career ends. The Plan also provides up to 90 months of payments to eligible players who incur a "substantial disablement" arising out of NFL football, even if they are able to work.

The collective bargaining agreements, and the current Plan document, reflect decades of care by the NFLMC and the NFLPA to shape these disability benefits. Annual benefits for total and permanent disability currently range from $18,000 to over $224,000. The amount each eligible player receives depends on a variety of factors, such as what caused the disability and how soon after leaving NFL football the player became unable to work. There are special rules and exceptions forged through collective bargaining. For example, players who are unable to work because of alcohol abuse or the use of illegal drugs generally receive a lesser benefit. Because of IRS limits, the NFLMC and the NFLPA have also established a companion plan—the NFL Player Supplemental Disability Plan—that only pays disability benefits in excess of the limits for retirement plans. The NFL Player Retirement Plan makes all eligibility and classification decisions for disability benefits.

In accordance with federal law, the NFL Player Retirement Plan is jointly administered by representatives of its Plan

sponsors, and has detailed procedures for the processing and review of all benefit claims. A Disability Initial Claims Committee ("Committee") makes initial decisions on claims for disability benefits. This Committee has two voting members—one appointed by the NFLPA and one appointed by the NFLMC. A player who is dissatisfied in any way with a decision of the Committee may appeal to the Retirement Board. The Retirement Board has six voting members—three appointed by the NFLPA and three appointed by the NFLMC. The members of the Retirement Board serve without pay and average over 20 years each in NFL-related experience, in positions such as a player, coach, agent, or owner.

The Plan maintains a national network of qualified physicians to review each claim for disability benefits. If a player appeals a decision of the Committee, that player is sent to a second physician in this network for a completely independent examination and review. Of course, players are invited to submit any evidence they wish in support of their claim, including reports of their treating physician.

In the 40 years of its existence, the NFL Player Retirement Plan has been sued by many players seeking additional disability benefits. To minimize the cost of this litigation, the Plan's sponsors—the NFLMC and the NFLPA—have deliberately given the Committee and the Retirement Board the broadest possible discretion in deciding claims. Pursuant to this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), decisions of the Retirement Board have been reviewed with deference under the arbitrary and capricious/abuse of discretion standard. Because the NFL Player Retirement Plan is jointly administered by a Retirement Board composed of equal numbers of labor and management members, courts have routinely held that the Retirement Board is not subject to a conflict of interest that might warrant less deferential judicial review. *See, e.g.*,

*Courson v. Bert Bell NFL Player Retirement Plan*, 75 F.Supp.2d 424, 431 (W.D. Pa. 1999), *aff'd*, 214 F.3d 136 (3d Cir. 2000).

The decision below will in many cases eliminate the discretion given to the Committee and the Retirement Board by the Plan's sponsors and settlers—the NFLMC and the NFLPA. The structure intended by these collective bargaining parties will be replaced by a requirement of deference to the views of a treating physician selected by the player. Litigation will increase and different rules will apply in different circuits. The NFL Player Retirement Plan therefore has a keen interest in the issue of whether the treating physician rule applies to ERISA plans.

## INTRODUCTION AND SUMMARY OF ARGUMENT

The court of appeals' decision, written by Judge Betty Fletcher, applies a rule created by the Social Security Administration ("SSA") to the claims decisions of disability plans voluntarily created by employers for their workers. This SSA rule, which is commonly referred to as the "treating physician rule," requires a high degree of deference to the views of the treating physician when deciding whether the claimant is entitled to disability benefits. For example, in the decision below, the Ninth Circuit found that the plan improperly relied on the reports of the independent examining physicians, and should have deferred to the views of the claimant's treating physician. Pet. App. 30a.

However, voluntary plans are governed by a different statutory scheme, the Employee Retirement Security Act of 1974, as amended ("ERISA"). ERISA is based on trust law and allows employers, as plan settlors, to determine the standards for benefits and whether trustees should be able to exercise discretion in deciding claims. ERISA provides protections for participants and specific procedures for

deciding claims. The Department of Labor has authority over claims procedures, and has issued detailed rules governing the consideration of disability claims.

Review of the decision is warranted for the following reasons.

I. There is a sharp conflict among the circuits on this core ERISA issue. The Third Circuit has endorsed the decision below, while six other circuit courts have rejected it.

II. The decision below violates important principles and precedents.

- In violation of ERISA Section 404(a)(1)(D), 29 U.S.C. § 1104 (a)(1)(D), it requires plan trustees and courts to disregard plan language governing the payment of benefits in favor of the opinions of a treating physician with respect to his patient.
- In violation of ERISA Section 503, 29 U.S.C. § 1133, it vests the Social Security Administration with de facto regulatory authority over ERISA plans. In ERISA Section 503, Congress granted the Department of Labor such authority. The decision below is incompatible with DOL's governing regulation. The DOL's scheme of two levels of review, and two independent medical examinations, is not compatible with the concept that a treating physician's opinion may be controlling.
- In violation of this Court's decision in *Firestone*, it eliminates the ability of a disability plan settlor to give trustees broad discretion in deciding claims.

III. The decision below will have adverse and unintended effects on ERISA disability benefit plans. Collectively bargained plan provisions will be invalidated. Benefit costs will increase because benefits will be paid to persons who were never intended to receive benefits. Litigation costs will

also increase as claimants challenge trustee decisions in different circuits by obtaining favorable reports from their treating physicians. These costs may cause employers to reduce benefits or terminate plans.

## ARGUMENT

### I. THE DECISION BELOW CREATES A CONFLICT AMONG THE CIRCUITS ON AN IMPORTANT NATIONAL ISSUE.

Over 38 million workers in this country are protected by disability plans voluntarily established by their employers. "Employee Benefits in Private Industry, 1999," United States Department of Labor, Bureau of Labor Statistics (Dec. 19, 2001). These plans range from extremely generous and complex schemes, such as the benefits of the NFL Player Retirement Plan, to more routine plan designs providing income replacement benefits where a worker cannot perform (depending on the plan terms) either his or her previous job or any job, to plans providing fixed benefits for specific disabilities, such as the loss of a limb. Disability benefits are a frequent subject of litigation.

The conflict in the Circuit Courts of Appeal on the treating physician issue is clear and growing. Prior to the decision below, five Circuits—the Fourth, Fifth, Seventh, Eighth and Eleventh Circuits—rejected the use of the treating physician rule in ERISA disability and health cases. *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834, 842 (8th Cir. 2001) (involving the same plan as in this case); *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607 (4th Cir. 1999); *Wilczynski v. Kemper National Insurance Companies*, 178 F.3d 933, 938 (7th Cir. 1999); *Dowden v. Blue Cross & Blue Shield of Texas, Inc.*, 126 F.3d 641, 644 (5th Cir. 1997) (per curiam); *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992); *Jett v. Blue Cross and Blue Shield*

*of Alabama, Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989). Prior to the decision below, no Circuit had applied the treating physician rule to ERISA disability or health cases.

Since the Ninth Circuit's decision, the Sixth Circuit has rejected the use of the treating physician rule. *Jackson v. Metropolitan Life*, 2001 WL 1450811 *2 (6th Cir. Oct. 29, 2001). The Eleventh Circuit has reaffirmed its rejection of the treating physician rule in ERISA cases. *Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270, 1274 (11th Cir. 2002) (involving the same plan as in this case).

However, the Third Circuit has endorsed the treating physician rule. *Skretvedt v. E.I. DuPont de Nemours and Company*, 268 F.3d 167, 184 (3d Cir. 2001) (citing the decision below). The Ninth Circuit followed its decision in *Regula* in *Nord v. Black & Decker Disability Plan*, 2002 WL 1492164 (9th Cir. July 15, 2002).

There are thus six Circuits that have rejected the use of the treating physician rule in ERISA cases, and two Circuits that have adopted it. This established and irreconcilable circuit split exposes benefit plans to conflicting standards when deciding claims for disability benefits under ERISA. The split frustrates "one of the principal goals of ERISA": establishing a "uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)).

The Ninth Circuit refused an invitation to review its decision en banc. Only this Court has the ability to harmonize this important area of the law. We urge the Court to grant the Petition for Writ of Certiorari.

## II. THE DECISION BELOW VIOLATES ESTABLISHED PRECEDENT BECAUSE IT STRIPS PLAN SETTLORS OF THEIR ABILITY TO SET STANDARDS FOR DISABILITY DETERMINATIONS.

Congress has given the Social Security Administration ("SSA") authority to set standards for the payment of disability benefits under the federal Social Security program. 42 U.S.C. § 405(a). In 1991, pursuant to this authority the SSA established, by regulation, the treating physician rule. In part, this rule states that "[g]enerally, we give more weight to opinions from your treating sources . . . If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight." Pet. App. 96a (20 C.F.R. section 404.1527(d)(2)).

SSA has no authority over voluntary plans established by private employers, and its rules do not apply to such plans. Voluntary plans are subject to the comprehensive rules of the Employee Retirement Income and Security Act of 1974, as amended ("ERISA"). The decision below violates ERISA in several respects.

A. ERISA does not require that an employer establish any disability, health, or retirement plans. *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995); *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996); *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 443-44 (1999). However, if an employer voluntarily offers employees a benefit plan, the plan's fiduciaries must administer the plan in accordance with the terms of the plan, unless prohibited by ERISA. 29 U.S.C. § 1104(a)(1)(D). ERISA thus codifies a basic principle of trust law regarding trustee responsibility. *See* Restatement (Revised Second) of Trusts § 541 ("A fundamental duty of

the trustee is to carry out the directions of the testator or settlor as expressed in the terms of the trust."); *Firestone*, 489 U.S. at 110 ("ERISA abounds with the language and terminology of trust law.").

The decision below squarely and improperly rejected the fundamental trust law principle that the specific language of an ERISA plan must be followed when reviewing claims for benefits:

> "[I]n the context of a disability claim such as Regula's, the key issue in determining whether a claimant is entitled to benefits is not the language of the plan, but the facts of the particular case. Hence, just as in Social Security cases, the issue in dispute in this case is not the meaning of the terms of the plan but whether the facts of Regula's case entitled him to benefits."

Pet. App. 18a. The decision below violates ERISA's fundamental directive that trustees must follow plan language unless otherwise directed by ERISA.

B. Congress has authorized the Department of Labor ("DOL"), not the SSA, to set standards for processing claims under ERISA plans. 29 U.S.C. § 1133. The DOL has issued elaborate procedures for handling disability claims under ERISA. Pet. App. 70a-95a (29 C.F.R. § 2560.503-1). For example, disability plans must offer claimants at least two levels of review by independent decision-makers, and perform an independent second medical examination on appeal. No DOL regulation or other authority has ever imposed any form of a treating physician rule on voluntary disability plans subject to ERISA.

The decision below is in direct conflict with Congress' directive to place the DOL in charge of the procedures for processing claims for ERISA benefits. Simply put, the decision below makes SSA an ERISA regulator. SSA may change, withdraw, or expand the treating physician rule,

thereby unwittingly changing the terms of ERISA disability plans. But Congress nowhere gave SSA such authority with respect to ERISA plans voluntarily established by private employers.

Moreover, the DOL regulations on processing claims for disability benefits under ERISA plans are not compatible with SSA's treating physician rule. The SSA rule requires deference to the views of a treating physician, who may in effect overrule the physician(s) selected by the ERISA plan pursuant to the regulations of the DOL (as in the decision below). The decision below thus improperly imposes on plan administrators and courts a particular method of weighing the evidence in the plan administrative record. This method may cause an award of benefits regardless of the terms of the plan.

C. The decision below violates this Court's decision in *Firestone*. In that case this Court determined that plan settlors may grant their designated trustees discretion to interpret plans and decide benefits, and that the general standard of judicial review where such discretion has been granted is the arbitrary and capricous/abuse of discretion standard. 489 U.S. at 115. *Firestone* is also based on the trust principle that a plan settlor may establish binding plan terms.

The decision below squarely holds that, even where the plan settlor explicitly gives the trustees discretion to decide claims, that discretion must be turned over to the treating physician. Indeed, if properly documented, the treating physician's views may be "controlling." The decision below cannot be reconciled with this Court's decision in *Firestone*.

## III. THE DECISION BELOW STRIKES COLLECTIVELY-BARGAINED PLAN PROVISIONS AND INCREASES THE COSTS OF DISABILITY PLANS.

The decision below extends the treating physician rule to all ERISA plans, including collectively-bargained plans that provide disability benefits like the NFL Player Retirement Plan. The Ninth Circuit's sweeping decision will have far-ranging effects on collectively-bargained disability benefits in particular, and on ERISA disability benefit plans in general.

The collective bargaining parties and settlors of the NFL Player Retirement Plan—the NFLPA and the NFLMC—have over decades very carefully and intentionally developed complex rules and generous provisions for the payment of disability benefits to eligible players. There are detailed rules regarding when a player is unable to work. For example, payments by an NFL club or a charitable organization may be disregarded in determining whether a player is capable of gainful employment. There are detailed rules as to when a disability arises from NFL football and entitles the player to a higher level of benefits. There are detailed rules that provide higher benefits to a player who is unable to work shortly after his NFL career ends. There are detailed rules that reduce benefits in some cases where a disability arises from abuse of alcohol or illegal drugs.

It is not, and never was, the intent of the NFLPA and the NFLMC to allow treating physicians to determine how these rules apply to players. The settlors of the NFL Player Retirement Plan intend that these decisions will be made by the Committee and the Retirement Board. The members of the Committee and the Retirement Board have extensive experience in reviewing claims. In addition, the NFLPA and the NFLMC have established a dispute resolution mechanism in which deadlocks with respect to a player's medical condition are resolved by a Medical Advisory Physician

("MAP") jointly appointed by management and labor. Under the terms of the Plan, a MAP's medical determination is final and binding on the Retirement Board. The treating physician rule renders the MAP mechanism ineffective, because it would set aside MAP determinations that are different than a treating physician's determinations.

The industry-specific disability rules developed over time for the NFL Player Retirement Plan are not unique. Other plans covering employees in other industries have similar specialized rules. For example, the collectively-bargained plan covering tens of thousands of bituminous coal miners provides disability benefits only to miners who become "totally disabled as a result of a mine accident," and the trustees of the plan have adopted detailed interpretative rules explaining how this standard is applied. *Brogan v. Holland*, 105 F.3d 158, 162 (4th Cir. 1997).

If the treating physician rule is superimposed upon these types of specially developed, industry-specific disability rules, the outcomes may bear little resemblance to the expectations of the collective bargaining parties. In *Brogan*, for example, two treating physicians opined that the claimant's disabling stroke occurred while he was on the job. Four examining physicians concluded that the stroke had occurred while he was at home. The court affirmed the trustees' decision to deny the claim based on their assessment of all the evidence in a manner consistent with their established interpretations of the plan standard. *Id.* at 162-63. If the court had applied the treating physician rule, the outcome may well have been different.

The payment of disability benefits to unintended claimants under the treating physician rule will increase the cost of disability benefits and reduce the amount of money available for other collectively-bargained benefits. The split among the

circuits will force inconsistent administration, magnifying litigation costs. Increased litigation costs also reduce the amount of money available for benefits.

These practical effects also apply to disability plans that are not collectively bargained. All disability plans may be required to pay disability benefits to unintended claimants, and plan settlers—employers—may elect to either reduce future disability benefits or decline to improve future benefits. The Ninth Circuit's decision will have the unintended consequence of reducing benefits for all qualified claimants.

Finally, there is no reason to conclude that the views of a treating physician selected by a claimant will be superior to the views of a physician selected jointly by labor and management trustees of a collectively-bargained plan. The NFL Player Retirement Plan retains only physicians who are believed by all to be objective and capable.

## CONCLUSION

The Petition for Writ of Certiorari should be granted.

Respectfully submitted,

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IN THE

# Supreme Court of the United States

DELTA FAMILY-CARE DISABILITY AND SURVIVORSHIP PLAN,

*Petitioner*,

—v.—

FRANK REGULA,

*Respondent*.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

## REPLY BRIEF IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI


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1.a. Although Respondent purports to show that "[t]he application of the treating-physician rule in the Ninth Circuit is consistent with the decisions of the other Circuit Courts of Appeal," Respondent's Brief at 7, Respondent (1) failed to even address two of the Circuits with which the Ninth Circuit is in conflict, and (2) has badly misread or misinterpreted the decisions made in the other four Circuits. The two Circuits that Respondent does not dispute are in conflict with the Ninth Circuit are the Seventh Circuit, *Wilczynski v. Kemper Nat'l Ins. Co.*, 178 F.3d 933, 938 (1999) and the Sixth Circuit, *Jackson v. Metropolitan Life*, 2001 WL1450811*2 (Oct. 29, 2001).

The decisions from other Circuits do not say what Respondent represents. In *Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270 (2002), the Eleventh Circuit held that "[t]he *Regula* decision is contrary to the law of this Circuit." *Id.* at 1274. Respondent asserts, however, that *Turner* ignored the Eleventh Circuit's prior decision in *Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321 (2001). The Eleventh Circuit knows its law better than Respondent: *Levinson* neither adopted nor mentioned the treating-physician rule.

In *Levinson*, the Eleventh Circuit held that the insurer's decision was arbitrary or capricious where *no* physician supported the insurer's denial. *Id.* at 1326-27.[1] *Levinson* does not even mention the treating physician rule in its discussion of whether the insurer's decision was arbitrary or capricious. *Id.* at 1325-27.[2]

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[1] At summary judgment, the insurer relied upon an affidavit of a physician who had not examined Plaintiff. Since the information post-dated the insurer's decision, the Eleventh Circuit did not consider it. *See id.* at 1325-27.

[2] Respondent's argument that the Eleventh Circuit "noted that the District Court had given less weight to the opinion of a reviewing physician and more weight to the treating physician relying upon

*Turner's* statement that the treating-physician rule did not apply in the Eleventh Circuit is a short-hand recognition of its holding in *Jett v. Blue Cross and Blue Shield of Alabama, Inc.*, 890 F.2d 1137, 1140 (1989) (the opinion of a physician who stood to gain as a result of his opinion would not be given deference). Since Respondent's physicians stood to gain financially from additional visits from Respondent as long as they continued to opine that he was entitled to benefits, just as the claimants' physicians did in *Turner* and *Jett*, the Eleventh Circuit is in square conflict with the Ninth Circuit's decision in *Regula*.[3]

Even a cursory analysis of the Fifth Circuit's decision in *Dowden v. Blue Cross and Blue Shield of Tex., Inc.*, 126 F.3d 641 (1997), shows that Respondent has also misrepresented the holding of that case. Respondent states that *Dowden* limited its holding so that it does not apply to disability-benefits claims. First, this is wrong since the Fifth Circuit rejected the treating-physician rule in a disability benefits case three years before *Dowden*. *See Sweatman v. Commercial Union Ins. Co.*, 39 F.3d

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*Donaho*. *Levinson* 245 F.3d at 1329," is irrelevant. Respondent's Brief at 15 (referring to *Donaho v. FMC Corp.*, 74 F.3d 894 (8th Cir. 1996). The portion of *Levinson* which discusses *Donaho* decided whether remand to the insurer was necessary. It referenced *Donaho* only in a historical description of the District Court's decision. *Levinson*, 245 F.3d at 1329-30. As noted above, it neither applied nor approved of *Donaho*, which, in any event, did not deal with the treating-physician rule. *See infra* at 3-4.

[3] Respondent's reliance on *Pegram v. Herdrich*, 530 U.S. 211, 218 (2000) to minimize the financial interests of the treating physician is unavailing. If the professional duties of the treating physician offset the obvious financial incentive for the treating physician, then the same obligation must more than offset the alleged bias of the independent physician. At best, Respondent's point undermines the Ninth Circuit's basis for discounting the opinions of qualified, independent medical experts. *See Petitioner's Appendix* 23a.

594, 601-02 (1994) (rejecting argument that treating physician should be given more weight). Second, the Fifth Circuit's actual holding in *Dowden* is much broader than Respondent represents. The Fifth Circuit held that giving the treating-physician's opinion any extra weight would conflict with the broad discretionary authority of the plan under the arbitrary or capricious standard, regardless of the type of ERISA benefit at issue:

> No evidence in the record exists nor does any legal authority stipulate that an attending physician's opinion should be granted *more weight* than the established policies and procedures of the plan administrator. To grant conclusive weight to the opinion of the attending physician would vitiate the discretionary authority expressly granted to Blue Cross in the contract.

*Dowden*, 126 F.3d at 644 (emphasis added). The Fifth Circuit rejected the treating-physician rule because it cannot be reconciled with *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), just as Petitioner argues in this case.

Respondent likewise contends that the Eighth Circuit is not in conflict with the Ninth Circuit even though the Eighth Circuit in *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834 (2001) reversed the District Court because it "incorrectly reasoned that the Plan should have accorded greater deference to the opinions of [claimant's] physicians." *Id.* at 842 (distinguishing *Donaho v. FMC Corp.*, 74 F.3d 894 (1996) as not applying to a conflict between *examining* physicians). While the Sixth Circuit in *Jackson* and a district court in the Eighth Circuit have also read *Marshall* as rejecting the treating-physician rule, *see Jackson*, 2001 WL1450811*2; *Brant v. Principal Life and Disability Ins. Co.*, 195 F. Supp. 2d 1100, 1111 (N.D. Ia. 2002), Respondent still contends that *Marshall* did not reject

the treating-physician rule. Respondent's confusion comes from comparing a rule regarding physicians who have only reviewed the records of a claimant as set forth in *Donaho*, and the rule at issue in this case and *Marshall*, which involves conflicting opinions of *examining* physicians. *Marshall* has rejected that the application of the treating-physician rule in ERISA cases, which puts the Eighth and Ninth Circuits in direct conflict in two cases decided under the same Plan.[4]

Respondent contends quixotically that the Fourth Circuit's decision in *Elliott v. Sara Lee Corp.*, 190 F.3d 601 (1999) does not reject the treating-physician rule, but then a page later asserts that the *Elliott* Court erred in not rejecting the treating-physician rule. *See* Respondent's Brief at 10-11. *Elliott* states that it would uphold the denial of benefits under the arbitrary or capricious standard "[e]ven if we were to apply the [treating-physician] rule to the ERISA [disability] claim before us, *which we are not persuaded to do*." *Id.* at 607-08 (emphasis added).[5] The Fourth Circuit has rejected the treating-physician rule in ERISA disability cases.

Ironically, Respondent's thesis, that the treating physician should be deferred to because of its intimate knowledge of Claimant's condition, is at odds with the reasoning of the only other Court that may support Respondent's position. In *Connors v. Connecticut General Life Ins.*

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[4] *Coker v. Metropolitan Life Ins. Co.*, 281 F.3d 793, 799 (8th Cir. 2002) and *Dodson v. Woodmen of the World Life Ins. Society*, 109 F.3d 436, 439 (8th Cir. 1997) do not support Respondent's view, but merely follow *Donaho* because the Plans did not rely on examining physicians in these cases.

[5] Contrary to Respondent's belief, *Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 126 (4th Cir. 1994) does not concern the treating-physician rule, but rather disapproved following the opinion of a physician who never examined the patient, thus drawing a distinction similar to the Eighth Circuit.

*Co.*, 272 F.3d 127, 135 n.4 (2001), the Second Circuit held that the treating-physician rule was to be used merely to encourage the development of a complete administrative record. Thus, the treating-physician rule would not apply when the Court's review was *de novo*. *Id.* (If this were the Ninth Circuit's view, it would lead to the ironic result that the treating-physician rule would not apply if the District Court applied a *de novo* standard on remand.) Further, since there is no dispute that the administrative record in this case was more than complete, the Second Circuit's logic would not apply to this case. When the cases are read fully and accurately, an active, growing split among the Circuit's on the treating-physician issue is apparent and three of these cases involve Petitioner.[6]

1.b. To minimize the chasm between the Circuits, Respondent recharacterizes the Ninth Circuit's holding to make it appear less drastic a departure from the settled rule in other circuits. An example is Respondent's discussion of the Third Circuit's decision in *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 46-48 (3d Cir. 1993), on pages 9-10 of Respondent's Brief. Respondent contends that the Third Circuit applied the treating-physician rule *sub silentio* in that case because it rejected a conclusory opinion of a treating physician in favor of a more detailed report from an independent physician that examined the plaintiff in that case. But

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[6] With respect to the Third Circuit, Respondent does not address the fact that the Third Circuit's language in *Skretvedt v. E.I. DuPont de Nemours & Co.*, 268 F.3d 167, 184 (3d Cir. 2001) is *dicta* because there was no conflict between physicians in that case. Thus, the rule in the Third Circuit is still, as expressed in *Abnathya v. Hoffman-LaRoche, Inc.*, 2 F.3d 40, 46-48 (3d Cir. 1993), that the Plan Administrator may reasonably choose between the conflicting opinions of examining physicians. *See infra*, at 5-6. *Skredtvedt* does signify, however, the growing confusion in the federal courts on this issue.

these are exactly the facts we have in this case and the Ninth Circuit reached a contrary result.

In this case, the majority did not discuss the relative merits of the doctor's reports. But Judge Brunetti in his dissent, Petitioner's Appendix (Pet. Ap.) 42a-43a, and the District Court *id.* at 58a-59a, concluded that the reports that the Plan relied upon were more detailed and more consistent than the reports submitted by Claimant and showed, in some instances, a bias of the physician to opine in *Regula's* favor without basis. Indeed, Claimant's physician *changed her opinion in Claimant's favor only after benefits were discontinued. Compare Pet. Ap.* 50a *with Pet. Ap.* 51a; *see Pet. Ap.* 58a-59a. If the rule in *Abnathya* was the treating-physician rule, the Ninth Circuit would have entered judgment for the Plan as the Third Circuit did in *Abnathya. See also Orvosh v. Group Ins. for Salaried Employees of Volkswagen of Am.*, 222 F.3d 123, 130 (3d Cir. 2000) (specifically permitting Plan to rely on an "equivocal" report of consulting physician which conflicted with the opinion of Claimant's physician). These divergent decisions cannot be harmonized as Respondent suggests.

The same is true with the Respondent's attempt to reconcile the Eighth Circuit's decision in *Marshall* with the treating-physician rule. While Respondent claims that *Marshall* effectively applied the rule because it reviewed the record "as a whole," it is clear that the Eighth Circuit never showed any deference to the opinions of Claimant's physicians in *Marshall* even though they were in open conflict with the opinions of the physicians that the Plan found more persuasive. *Marshall*, 258 F.3d at 842.

The Ninth Circuit's decision is drastic departure from a settled cross-Circuit consensus which rejects more complete, more consistent reports in favor of those of the Claimant's physician who has a pecuniary interest in

Respondent's successful retention of benefits. Respondent's efforts to hide the effect of the Ninth Circuit's decision reflects his true understanding that the Ninth Circuit's decision has created a major conflict.

2. Respondent's reference to public disability programs that adopt or use the treating-physician rule only reinforces Petitioner's point that there is a stark contrast between private disability plans, which are permitted to decide what benefits to provide and under what terms to provide them, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 91 (1983); *Inter-Modal Employee's Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 515 (1997) (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985)), and the highly regulated nature of public disability plans, such as Social Security.[7]

In fact, with regard to the only two private benefit systems referenced in Respondent's brief, both the law at issue in *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021 (2002) and the Department of Labor's ERISA claim regulations, *neither* require deference to a treating physician. Rather, they both involve systems where, in the event of a conflict, an *independent physician's* opinion shall control or at least be considered. *See Moran*, slip op. at 3; 29 C.F.R. §2560.503-1(h)(4) (referring to § 2560.503-1(h)(3)(iii)); Pet. Ap. 82a-84a. Neither Respondent, nor the Ninth Circuit, explain how the regulation's requirement for independent review can be reconciled with the Ninth Circuit's holding that deference must be paid to the treating physician. Thus, the Ninth Circuit's judicial rule-making under the aegis of "federal

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[7] *Amicus Curiae* The ERISA Industry Committee points out that while an overwhelming majority of ERISA disability benefit claims are approved, less than half of Social Security Act disability claims are approved. Brief of *Amicus Curiae* The ERISA Industry Committee at 4-5. Thus, there may be a practical reason for this distinction as well.

common law" cuts against ERISA's calculated decision to allow private benefit plans to define their own scope.[8] *See White v. Principi*, 243 F.3d 1378, 1381 (Fed. Cir. 2001) (rejecting treating-physician rule in Veterans Affairs benefits cases because the Secretary of Veterans Affairs had not adopted the rule).

3. Respondent's conclusory allegation that the *Regula* decision does not conflict with the decisions of the Third, Seventh, Tenth and Eleventh Circuits on the conflict of interest rule is unsupported. Respondent offers no analysis of these cases, giving the Court no reason to accept his premise that a conflict does not exist. While Respondent relies on *Moran* for this point, *Moran* is no balm for Respondent. *Moran* did not involve a plan funded by a trust with irrevocable contributions and did not even discuss the conflict issue as it applies to this case. Rather, *Moran* dealt with an entity that both decided benefit claims and paid benefits out of its general assets. *See Moran*, slip. op. at 9. The Circuit Courts, except for the Ninth, have consistently treated those types of insurers differently from self-funded plans, like the one in this case that pay benefits out of funds from which the employer can never recall any of the amounts contributed. *See Abnathya v. Hoffmann-La-Roche, Inc.*, 2 F.3d 40, 45 n.5 (3d Cir. 1993); *Gallo v. Amoco Corp.*, 102 F.3d 918, 921 (7th Cir. 1996); *Woolsey v. Marian Lab's, Inc.*, 934 F.2d 1452, 1459 (10th Cir. 1991); *Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270, 1274 (11th Cir. 2002). The incen-

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[8] Respondent incorrectly states that the Plan claims that ERISA preempts other federal laws. The Plan cites ERISA's preemptive force as evidence that a disruption in the uniformity of plan administration—in this case a clear Circuit conflict—is contrary to ERISA's uniformity goal. This is especially so since this Plan is self-funded. Thus, the savings clause's exception to preemption does not apply. *Moran*, slip. op. at 14 n.6.

tive of a self-funded plan administered by an employer's employees is to provide the promised benefits according to its terms is a critical distinction neither at issue in *Moran* nor dealt with by Respondent. None of these cases recognize a middle ground as inferred by Respondent that some irrevocably-funded trusts are different than others. Thus, this Court's intervention is necessary to resolve this important issue which currently divides the Courts of Appeals.

Respectfully submitted,

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